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MAYOR'S HIV HEALTH SERVICES PLANNING COUNCIL

January 26, 1998

San Francisco AIDS Foundation, 10 U.N. Plaza, 6th Floor Conference Room

AGENDA

I.	Call to Order	4:30 PM
II.	Roll Call	
III.	Review and Approval of Agenda	
IV.	Review and Approval of Minutes of 12/15/97	
V.	General Announcements	
VI.	Public Comment	
VII.	Reports	5:00
	A. PWA Caucus Report 2/4/98 5:00 – (7:00?)	
	1. Consumer Rights Advocate (VOTE)	
	2. Inclusion of PLWHA	
	B. Membership Committee Report 2/6 9-11 @ AD	
	C. Planning Committee Report 2/5 3:00 @ AD	
	D. Eval Comm 2/2 5:00	
	BREAK	6:00
	D. AIDS Office Report	6:15
	1. Grant Award	
	2. VNH Contract	
	3. REGGIE Update	
	E. Steering Committee Report	6:45
	1. Retreat	
	2. Committee Structure (VOTE)	
	3. Planning Council Support (VOTE)	
VIII.	New Business	7:15
IX.	Adjournment	7:30

Up-coming Meetings:

Feb. 23, 1998 - Planning Council, SFAF, 10 UN Plaza, 6th Floor Conference Room, 4:30 - 7:30 PM

San Francisco AIDS Foundation, 10 United Nations Plaza:

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San Francisco Department of Public Health, AIDS Office, 25 Van Ness:

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HIV HEALTH SERVICES PLANNING COUNCIL

January 26, 1998

The Minutes of this meeting are missing.

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HIV HEALTH SERVICES PLANNING COUNCIL

February 9, 1998

The Agenda of this meeting is missing.

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Mayor's HIV Health Services Planning Council
Minutes of Meeting

February 9, 1998

FILE

I. Call to Order: 5:10 p.m.

II. Roll Call [1]

III. General Announcements:

A. *MS* announced the SF AIDS Foundation will be holding a women's advocacy training seminar on April 9, and is in need of HIV+ women to help coordinate, volunteer as mentors, etc. Those interested can contact *MS*.

B. *VC* announced that the HIV/AIDS prison program run by *Judy Greenspan* may be forced to close soon due to financial trouble, and suggested that the Council consider ways in which it may aid this important program.

I. Public Comment:

A. *Jim Illig*, President of the HIV Contractors Association, explained that contractors are attending this meeting to ask the Council to direct the AIDS Office to extend the RFP response time a minimum of sixty days. He explained that CBOs are in favor of the new service model outlined in the RFP, but need tools, training and time in order to effect the changes involved. The Contractors Association feels that the deadlines given in the RFP are therefore unreasonable, and demonstrate poor understanding of how CBOs operate. *JI* reminded the Council that organizations which already use models of integration, such as the Bridge Project and TARC, testified in past CARE meetings that development of their integrations required significant technical assistance, time and administrative funding. He also noted that the Council and providers repeatedly asked the AIDS Office for its definition of "integration service model", and were told to wait for the RFP release. In addition, the AIDS Office delayed that release for two months, due to the HRSA award delay, when it could have informed contractors at least of its content in order to allow them more time to prepare responses. Many contractors still have not received letters from the AIDS Office informing them of their funding status in 1998-99. In closing, *JI* said that contractors are willing to work with the AIDS Office to expedite contract negotiations, which do not have to take three months.

B. *Paul Causey*, of AIDS Benefits Counselors, reiterated that the details which need to be addressed in order to make the service changes outlined in the RFP require more time than is allowed by the current deadline. He asked the Council to direct an extension of that deadline by at least sixty days, to be offset by a reduction in the AIDS Office response time, which contractors will aid the office in meeting.

C. *Guy Vandenberg*, of Continuum HIV Services and Tenderloin Care, expressed strong support for the creation of an integrated service system, and stated that in order to fully honor that direction the providers involved need more time to craft relationships which will most benefit their clientele. He also noted the irony of calling for collaboration while simultaneously requiring providers to compete for funding.

D. *Allen Meyer*, Director of Programs for the Sam Francisco Community Clinic Consortium, informed the council and its guests that the Consortium, Haight Ashburry free Clinics and Lyon Martin Women's Health Services were informed last week that their primary care contracts will not be renewed in 1998-99, and that their funding will be terminated June 30. He recalled that at the bidders conference last week it was announced that the SF DPH primary care programs will continue to receive full funding. Given the Council's top priority ranking of primary care services, *AM* wished to make it clear that the funding cut to the organizations he represents (including Haight Ashburry Free Medical Clinics, Lyon Martin Women's Health Services, Mission Neighborhood Health Center, Native American Health Center and South of Market Health Center), will have a devastating effect on their ability to provide quality, culturally competent, comprehensive community and neighborhood-based primary care to a diverse population. He listed the following questions for consideration by the Council: 1. Is the decision to cut these organizations' primary care funding consistent with the Council's priorities? 2. Does the Council believe that this AIDS Office decision is in the best interest of the nearly 100 patients currently choosing to receive primary health care services in community and neighborhood-based clinics? 3. What will the likely impact of this decision be on patients' continuity of care and medication adherence? 4. Is there a conflict of interest for the AIDS Office to give preferential treatment to SF DPH clinics? 5. Does this Council agree with the AIDS Office that with this new RFP there is now a "level playing field" for awarding funds? 6. Does this Council support the notion that there should be a CARE Act funding "carve out" for DPH clinics, which will continue to receive funding without apparent regard to their performance as measured by monitoring protocol? 7. Is this Council aware that the last time there was a competitive performance review involving SF DPH clinics for a case management funding cut in 1996, the SF DPH's community public health services clinics received by far the fewest points of the programs evaluated? (*AM* noted that he brought documentation of this assertion for review by the Council, if desired). In closing, *Mr. Meyer* assured the Council that SFCPC and its partner health centers will pursue all available avenues to allow their continued delivery of primary care services, and asked that the Council lend support in whatever way it deems appropriate.

MJW asked how much funding *AM*'s programs received in 1997. He replied that they received approximately $1.2 million.

E. *Dick Pabich*, coordinator of the recent HIV/AIDS Summit, announced that he will be the Mayor's Office liaison to the CARE Council, and the person responsible for Council membership issues. He requested that the Council schedule a discussion of the summit recommendations at a future meeting, to inform the Mayor's Office on its position. *DP* also informed the Council that its recommendations regarding the positions currently open in that body have been received by the Mayor, and a response will be given soon. Finally, he noted that several people have served on the Council for more than a year, and need to re-apply and be appointed again to continue their membership.

DJ asked *Mr. Pabich* if he will be attending Council meetings. He replied that he plans to.

F. The following guests expressed concern for the effect which the 1998 budget will have on services for women and children: *Janis Falco*, of Coalition for Positive Families and Children; *Nan O'Connor*, of the Coalition for Positive Families and Children, and the Center for Special Problems; *Kathleen Manthe*, of Rita da Cascia, CCASF and CPFC; *Dorothy Goldstone*, of MOMS; *Rita Shimmin*, of Lyon-Martin Women's Health Services. They also noted that women's and children's services have formed collaborations in the past, out of necessity due to limited funding, a dearth of women-and children-focused programs and the integrated manner in which problems present themselves in these populations. However, the new RFP provides an opportunity for these collaborative relationships to be improved, if providers are given time. *Dorothy Goldstone* added that in the past years progress has been made in creating a service system specifically for women and children with HIV and AIDS, and that system is now threatened.

G. *Nan O'Connor*, *Kathleen Manthe*, and *Linda Hammond*, of Circle Counseling Center, expressed opposition to the $850,000 cut to mental health services.

H. *James Beck*, of Haight Ashburry Free Clinics and Neighborhood Council, said that the CARE integrated service RFP requires greater input from the community, consumers and boards of directors. He suggested that in order to effectively solicit input from the community it is important to go to community meetings, etc.

I. *Lara Salee*, of Haight Ashburry Free Clinics, reminded the Council that integration requires not only the input of providers and their boards of directors, but also of their clients. This is another reason why providers should be given more time to respond to the RFP.

J. *Josefa Molina*, of Instituto Familiar de la Raza, admonished the Council and guests not to forget the special needs of individual communities in the larger process of service system integration.

K. *Deb Self*, of the San Francisco Food Bank, suggested that a brief needs assessment be conducted in order to help providers ascertain the links and collaborations which will best meet the needs of their target populations. There also need to be provisions in place to assess collaborations over time and make changes when necessary. She expressed the concern that if these things are not considered, and providers not given more time to develop the new system, then the changes will be superficial and poorly crafted.

L. *Valerie Edwards*, of Westside Community Mental Health Services, explained that organizations with active boards of directors and a desire to gain the input of clients, other providers, etc. into their programmatic changes can not effect the reorganization which the new RFP requires, and which providers support, in the amount of time given.

M. The following guests (in addition to those already noted) requested that the RFP response deadline be extended by at least sixty days: *Tiffany Mock-Goeman*, of Catholic Charities; *Janis Falco*; *Nan O'Connor*; *Kathleen Manthe*; *Carla Wilson*, of the Quanjin Healing Arts Center and CPFC; *Rita Shimmin*; *Lara Salee*. (Some of these guests made additional comments, which are outlined above).

Discussion:

LT asked that an AIDS Office staff member speak to the possible implications of granting the request for a sixty-day delay on RFP responses. *Billy Pick*, of the AIDS Office explained that his purpose at this meeting is to report provider input and Council discussion back to the AIDS Office for consideration, but he is at this time unable to speak on behalf of the office regarding implications of the request or how it will effect RFP timeline decisions. However, the AIDS Office will be discussing the proposed response delay with *Jim Illig*, president of the Contractors Association, and *Paul Causey*, Contractors Association treasurer, among other association officers, to develop a plan which better meets the needs of providers. *BP* noted that the timeline was arranged to allow timely service start-up, and was based on the historical fact that contract negotiations often take some time. Contractors Association representatives have said that providers will expedite their contracts in a more timely manner than they have in the past, which will be taken into account in discussions of the response deadline. These discussions will begin tomorrow (February 10).

Nan O'Connor asked when the contractors who have not received their award notification can expect them. *BP* replied that they should have all been received, and may be held up in agencies' executive directors' offices. *DJ* reminded the group that specific contracts should not be discussed at this time.

BP noted that the RFP timeline may not fall within the Council's purview, and added that according to the Sunshine Act the proposal made by contractors can not be addressed at this meeting because it was not on the agenda. He suggested that the issue be left for the AIDS Office to discuss with the Contractors Association. *DJ* agreed that the Council could not accept or reject the proposal, but noted that its job is to hear provider input and direct the grantee in its response. She suggested that the Council discuss the proposal at this time in order to provide direction to the AIDS Office.

JC informed those present that the Council did not set the RFP timeline, and expressed his sympathy for contractors' predicament. He also expressed concern regarding the implication that prioritization decisions were made without sufficient input from community members, providers, etc., and noted that the process included a considerable amount of outside feedback, which the Council values highly.

LT recognized the urgency of beginning new services, which was exacerbated by the HRSA award delay. However, she urged the AIDS Office to recognize the importance of allowing providers time to craft those services carefully, so that they may best meet the needs of their clientele.

JG admonished Council members to listen to the providers, and expressed the concern that failure to do so will result in service system chaos. He reiterated that integration of services requires significant time and technical support, and recalled that the Council itself tried to define integration for months without success. He also asked why funding cuts must be sustained at this level, and suggested that the Council solicit city funding rather than accept a decrease in HIV/AIDS services. In closing, *JG* urged the Council not to allow an unreasonable timeline for service system changes to adversely effect the community it is charged to serve.

DJ informed the group that no cut was made to primary care services.

JG clarified that although the Council did not authorize cuts to primary care, the way in which the AIDS Office has directed the service system changes will cause a reduction in service. He expressed the opinion that this has been a strategic attempt by the DPH to force more patients into the public health system in an effort to move toward a single-provider system.

GG expressed concern regarding the gap between the end of the current contract year and the start-up of new services. He noted that a sixty day extension for any part of the process will lengthen that time, creating a dangerous service gap. In addition, unexpended funds caused by the resulting shrinkage of the 1998 service year will prove problematic at the end of FY1998. Because of these concerns, *GG* suggested that the RFP response delay be less than sixty days.

SL noted that although some providers historically submit their proposals late, if they are not given sufficient time to develop sound proposals then the entire year will be spent discovering errors and making adjustments. He expressed the opinion that it would be better to take the time now then extend the transition time throughout the year.

TC outlined part of the CARE Act mandate regarding the Council's instruction and assessment of the grantee. He said that, according to the CARE Act, it is within the Council's purview to address this issue. *TC* expressed the opinion that the most fundamental goal of the CARE Council is to improve care services for PLWH, which it is working hard to do. The current direction of the Council has received approval by HRSA, and appears to be advanced in relation to other service systems and geographic areas. He acknowledged the difficulty of providers' position at this time, but noted that the need for providers to have time to develop proposals must be balanced with the need to start new services in a timely manner. Regarding technical assistance, *TC* recalled that at the Mayor's HIV/AIDS Summit reference was made to funding from Macey's Passport and Glaxo Welcome, to be made available to contractors for technical assistance in planning grants, as part of the AIDS Leadership Forum. He asked *Dick Pabich*, of the Mayor's Office, to investigate the availability of that funding and communicate his findings to the Contractors Association.

WC reiterated the concern that extending the process at this point would create problems in the future, and suggested that the contractors and AIDS Office work toward a compromise involving extension of the proposal due date and a decrease in the contract negotiation and processing time. He also reminded the AIDS Office that although the Council recognizes the difficulties presented by its current internal reorganization, the office's responsiveness to contractors will figure into the Council's evaluation of the grantee.

BC recalled that during the prioritization process many people of color spoke to the Council regarding community needs, and observed, with concern, that very few have come to this meeting.

MJW recognized both the need for providers to have more time to develop proposals and of the AIDS Office to have sufficient time for the processing of those proposals. She suggested that 1997-98 contracts be extended longer than the four months currently planned in order to allow more time for the preparation of new contracts by all involved. As long as the Council, providers and AIDS Office are confident that the desired integrations will come about, it may be wiser to delay the entire process a bit longer in order not to sacrifice any part of it.

DJ observed that the meeting is behind schedule, and proposed that ten more minutes be allocated to the RFP issue on the table, and then the Council move on to the Steering Committee report. The Council took a voice vote and the proposed agenda passed unanimously.

JG offered the following motion: *it is the sense of the CARE Council that the AIDS Office extend the RFP and contracting processes by 120 days, and the matter be reviewed by the CARE Council at its meeting on February 23.* He explained that 120 days may not be the right amount of time, but it is likely that providers will need more than sixty.

Marsha Herring, of the AIDS Office, expressed support for the requested extension, and informed the Council and guests that the AIDS Office will soon be losing over 50% of the staff involved in the contracting processes, meaning that those processes should be expedited before the new staff begin.

JG responded that contractors should not sacrifice the best interest of their clients to the AIDS Office staffing schedule.

Billy Pick reiterated his previous suggestion that the AIDS Office discuss the contracting process and timeline with Contractors Association representatives, noting that the CARE Council does not directly represent providers, while the association does. Thus it may be more appropriate for this discussion to occur elsewhere.

MJW expressed agreement with *BP*, but noted that the AIDS Office should enter discussion with the Contractors Association already informed of the scheduling changes which the Council would support.

TL expressed the opinion that anything which effects the delivery of services to PLWH in San Francisco is within the Council's purview. Thus, it is the duty of this body to respond to any and all community and provider concerns in the best way possible. Regarding the allowability of voting on unscheduled issues, under the Brown Act, *TL* read the City Attorney's position: if the effort is so imperative that it can not wait until the next meeting, then the body can choose to hold the unscheduled vote. Given this information, *TL* agreed with the motion to express support for an extension of the RFP response date, but suggested that an exact amount of time not be specified by the Council. *He moved that the CARE Council recommend to the AIDS Office that the sense of the Council is to delay the implementation of the timeline in a manner appropriate to the full development of contract proposals. LT* seconded the motion.

JC offered the friendly amendment that the Council ask AIDS Office staff to report the finalized timeline at its next meeting.

JG added another friendly amendment: the timeline is to be negotiated with the Contractors Association.

TL accepted both amendments.

MJW expressed opposition to the second amendment on the grounds that it is inappropriate for the AIDS Office to "negotiate" RFP-related issues with the Contractors Association.

JG changed the wording of his amendment to: the timeline is to be developed in consultation with the Contractors Association. *TL* accepted this change.

WC invited contractors and AIDS Office staff to comment on the proposal before the vote is held.

The motion restated: *the CARE Council recommends to the AIDS Office that it delay the implementation of the timeline in a manner appropriate to the full development of contract proposals; that the timeline be developed in consultation with the Contractors Association, and the AIDS Office report the finalized timeline back to the Council at its February 23 meeting.* A roll-call vote was held and the motion passed, thirteen in favor, none opposed and four abstaining due to conflicts of interest [2].

WC reminded Council members to state conflicts of interest before entering into discussions to which those conflicts apply, as directed in the by-laws.

V. Steering Committee Report:

A. **Planning Council Support:** *TC* reviewed the Planning Council support budget proposal which was included in the pre-meeting mailing (see mailing entitled "Planning Council Support"). This proposal was developed at the Steering Committee retreat held January 10, 1998. He recalled that in its prioritization process the Council designated $250,000 for this service, and discussed the suggestion that the Council hire its own support staff, rather than contracting it through and within the AIDS Office. The $250,000 is intended to provide clerical support, technical assistance and data analysis to the Council, as well as the establishment of an HIV Consumer Rights Advocacy service.

MJW moved to approve the proposed budget.

SL spoke in favor of the motion, and expressed the opinion that the process through which the proposed budget evolved was thoughtful and thorough. He noted that the proposal is, however, missing a statement regarding the intent to seek other funding streams to support the HIV Consumer Rights Advocacy service. *TC* explained that the possible contribution of HOPWA and General Fund dollars to the advocacy service will be examined.

JC seconded the motion.

WC noted that advocacy services are currently being discussed by many groups, and the possibility of combining/collaborating/cooperating, with other programs will be explored, with the hope that another source of funding may be discovered.

TL called a question. A roll-call vote was held and the proposed budget, unchanged, passed unanimously [3].

TL informed the Council that, according to the Brown Act, two motions must be passed in order for the previous vote (regarding the contracting process timeline), to pass. The first of these motions is: *the Council makes a finding that it did not have the information involved in that vote in a timely manner to mail to members in advance or include on the meeting agenda. TL* moved to make that finding, and the motion was seconded. A voice vote was held, and passed unanimously.

The second motion necessitated by the Brown Act is: *the Council makes a finding that it would be injurious to the public to delay the decision* (regarding the contracting process timeline). *TL* moved to make that finding, and the motion was seconded.

JG asked if conflicts of interest apply to this vote. *TL* replied that they do not, because it is a procedural question not relating directly to the original issue of the timeline.

A voice vote was held, and passed unanimously.

B. Unexpended Funds: *TC* announced that *Michelle Long Dixon*, AIDS Office liaison to the CARE Council, informed the Council at the end of its January 26 meeting that unexpended funds have been identified in the 1997-98 budget. These funds total $275,000 and must be encumbered by midnight on February 28 or they will be revoked. More funds may be identified as the contract year closes.

LT reviewed some of the past uses for unexpended funds: 1. non-ADAP drugs 2. direct emergency financial assistance 3. purchase of additional units of service in agencies providing service beyond their budgets 4. Planning Council support-related assessments and studies 5. vouchers for food, clothing, transportation and alternative therapies 6. one-time, fixed asset expansion costs in specific agencies.

TC informed the Council that some of the vouchers which were purchased with previous years' unexpended funds are contained in the most recent RFP, and have been in the AIDS Office for years. Therefore, it may not be necessary to purchase more vouchers.

MJW moved to use the entire $275,000 in unexpended funds to purchase non-ADAP drugs. She cited two reasons for this use: it is the fastest way to commit the funding, which must be done in nineteen days, and it would be of almost immediate benefit to clients. *TL* seconded the proposal. *MJW* added that the ADAP Medical Advisory Committee (of which she is a member), has recommended that anti-depressants, vaccines and antibiotics be added to the formulary, if funding permits.

BC suggested allocating some of the unexpended funds for rent subsidies.

MD expressed the opinion that rent subsidies would be an unrealistic use of this funding, given the amount of time for which it will remain available.

TC clarified that the funding must be *encumbered* by February 28, but can be spent after that date.

TL asked the AIDS Office staff present how difficult it would be to implement the allocation of a portion of the funding to direct emergency financial assistance.

David Jenson, Board member of the AIDS Emergency Fund, noted that the AEF Board would be able to begin processing an additional allocation immediately, to ensure that it go directly to clients in a timely manner.

TL offered the friendly amendment that 60% of the unexpended funds be used to purchase non-ADAP drugs, and 40% be allocated to direct emergency financial assistance. *MJW* said that she would accept the amendment if the AIDS Office staff can insure that it will be implemented. *Billy Pick* replied that the ability of the AIDS Office to implement that plan depends on whether the funds actually have to be spent, or simply encumbered, by February 28, which remains unclear. *TC* noted that his interpretation that it need only be encumbered is based on a statement made to him by *Michelle Long Dixon*.

TL suggested that the motion call for *60% of funding to non-ADAP drugs and 40% to direct emergency financial assistance, if that split is possible. If it is not possible in the time given, then 100% of funding will be used to purchase non-ADAP drugs. MJW* accepted this amendment.

MD asked what constitutes direct emergency financial assistance. *TC* explained that there is a service category bearing that name, to which this funding would be allocated.

The motion was seconded.

BC expressed the opinion that direct emergency financial assistance may be a better use of funds than non-ADAP drugs because it allows PLWH to use the money as they need it, and not all need non-ADAP drugs. Those who do require non-ADAP drugs can buy them with direct emergency financial assistance money.

Jim Illig, of the Contractors Association, explained that in the five years during which he has been involved in unexpended fund decisions, those funds have always had to be *spent*, not just encumbered, by the end of the contract year. He added that the way this money can be used now is only to reimburse an agency which has already spent the amount given. Therefore, if awarded to non-ADAP drugs, the funding will go to the SF General pharmacy, thereby subsidizing the DPH. He expressed the opinion that the unexpended funds should instead be allocated to a CBO.

TC restated the motion. A roll-call vote was held, and the motion failed, ten opposed and seven in favor [4].

LT asked those who voted against the motion to explain why.

VC explained that she is opposed to the money going to the SF General pharmacy, and would prefer it all go toward direct emergency financial assistance, allowing each client to spend it on the services s/he needs most. *JG* expressed his agreement.

BC expressed concern regarding the 60:40 split outlined in the proposal, and the uncertainty about whether that would be possible to implement.

JG moved to allocate 100% of the unexpended funds to the direct emergency financial assistance service category. The motion was seconded.

SL spoke in favor of the motion, and asked AIDS Office staff to address *Jim Illig*'s assertion that funding for non-ADAP drugs goes directly to the SF General pharmacy. *Billy Pick* and *Marsha Herring* expressed uncertainty regarding the assertion, but noted that money must go to the category specified, and can not be moved from one to another. They also assured the Council that, whatever category is funded, the money will only serve PLWH.

TL asked the AIDS Office staff if the entire $275,000 in unexpended funds can be given to direct emergency financial assistance by February 28. They replied that it can.

MD suggested that an alternate plan for the funding be proposed, in the advent that it can not be used in the category proposed before the deadline.

Marsha Herring stated that, although the AIDS Office can not *promise* the outcome, its staff will do whatever is necessary to see that the money is spent on time and according to the Council's wishes.

JG proposed that if the funding can not be spent on direct emergency financial assistance, it go to non-ADAP drugs.

DJ stated that she has a conflict of interest in this discussion due to her employment at SF General Hospital (although not in the pharmacy). She suggested that, at some point, the Council get clarification on how the various funding streams combine in the system.

WC recalled that non-ADAP drugs were discussed last year when unexpended funds became available, and expressed frustration that the Council did not get information on non-ADAP drugs sooner so that it could make a more educated decision regarding this year's allocation. He expressed support for the proposal to allocate 100% of extra funding to direct emergency financial assistance, and recalled that one provider in that category has had to reduce its yearly grant amount and restrict its service area due to lack of funding. In closing, *WC* spoke against the amendment.

JC expressed his support for the amendment on the grounds that it is prudent to have a second plan in case the first proves impossible to implement. He also noted that it would be preferable for the unexpended funds to go to the SF DPH than be lost from the system entirely.

TC restated the motion: *the $275,000 in identified unexpended funds for FY 1997-98 be allocated to direct emergency financial assistance, and any funds not spent by midnight, February 28, be used to purchase non-ADAP drugs.* A roll-call vote was held and the motion passed unanimously [5].

VI. **Adjournment**: 7:00 p.m.

ATTENDANCE AND VOTING RECORD

P=present; A=absent; E=excused; L=leave of absence; Y=yes; N=no; B=abstain; R=proxy

	1	2	3	4	5		1	2	3	4	5
James Abrams	A					Danny Joe	A				
Kirsten Balano	E					Diane Jones	P	Y	Y	Y	Y
Marianna Balquiedra	P	Y	Y	Y	Y	Susan Larp	P	Y	Y	N	Y
Jeff Byers	A					Tony Leone	P	Y	Y	Y	Y
Virginia Cafaro	A					Steve Lew	P	A	Y	N	Y
Tom Calvanese	P	Y	Y	N	Y	Norm Nickens	L				
William Carter	P	Y	Y	N	Y	Carmen Portillo	A				
Bart Casimir	P	A	Y	N	Y	Ron Reynolds	A				
Veronika Cauley	P	Y	Y	N	Y	Alissa Riker	P	Y	Y	N	Y
Michael Chesek	A					Nilda Rodriguez	A				
Pat Christen	A					Joy Rucker	L				
John Conley	P	Y	Y	Y	Y	Barry Savage	A				
Mark Dunlop	P	Y	Y	Y	Y	Matthew Sharp	P	Y	Y	N	Y
Miriam Farooq	A					Thomas Sinclair	A				
Carol Gong	A					Laura Thomas	P	Y	Y	Y	Y
Gene Gowdey	P	A	Y	N	Y	Rita Times	A				
John Gressman	P	A	Y	N	Y	Brett VanBenschoten	A				
Dee Hampton	A					Kelly Wallace	A				
Ron Hill	A					Mary Jane Wood	P	Y	Y	Y	Y

The Council meets on the first and third Monday of each month, at the time and place noted above. All are welcome and have the opportunity to comment on agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff at 554-9136. To request an excused absence (Council members only), contact Emily Coles at 777-3229. *Minutes of meetings are tentative until formally approved by the Council.*

Mayor's HIV Health Services Planning Council

February 23, 1998
4:30 - 7:30 p.m.

Note New Location:
AIDS Office, 25 Van Ness Avenue, 3rd Fl. Conference Room 330A

AGENDA

✓ I.	Call to Order	4:30 p.m.
✓ II.	Roll Call	
✓ III.	Review and Approval of Minutes	
✓ IV.	General Announcements	
✓ V.	Public Comment	
VI.	AIDS Office - Michelle Dixon	5:00 p.m.
	✓ REGGIE Update - Jan Gurley	
	✓ RFP Update/Timeline	
	✓ Unexpended Funds Update - Art	
VII.	Committee Reports	5:50 p.m.
	✓ 1. PWA CAUCUS: Policy Recommendation on Increasing PLWH/AIDS Inclusion on Agency Staff and Board (VOTE)	
	✓ 2. MEMBERSHIP: Report on Review of Attendance of Council Members and LOAs (VOTE)	
✓	BREAK	
	3. PLANNING: Report	
	4. EVALUATION & ASSESSMENT: Report	
	5. HOUSING: Report	
VIII.	Steering Committee Report	7:15 p.m.
IX.	New Business New business	7:20 p.m.
X.	Adjourment Adjournment	7:30 p.m.

Upcoming Meetings

March 2 - Evaluation and Assessment, AIDS Office, 25 Van Ness , 5:00-7:00 p.m., 3rd Fl. Conf. Rm 330A
March 4 - PWA Caucus, AIDS Office 25 Van Ness, 5:00-7:00 p.m., 5th Fl. Conf. Rm.
March 5 - Planning, AIDS Office 25 Van Ness, 3:00-5:00 p.m., 3rd Fl. Conf. Rm 330B
March 6 - Membership, AIDS Office 25 Van Ness, 9:00-11:00 a.m., 3rd Fl. Conf. Rm 330B
March 9 - Steering, AIDS Office 25 Van Ness, 5:00-7:30 p.m., 5th Fl. Conf. Rm .
Housing - TBA
March 16- Planning Council, AIDS Office, 25 Van Ness, 4:30-7:30 pm., 5th Fl. Conf. Rm
March 23 - Planning Council, AIDS Office, 25 Van Ness, 4:30-7:30 pm., 3rd Fl. Conf. Rm. 330A

San Francisco Department of Public Health, AIDS Office, 25 Van Ness:

The site is fully accessible, and assistive hearing devices and signing are provided upon adequate notice. Minutes of Meetings and all information distributed to the Council Members, are available for inspection and copying. For further information, call the Council's staff, 415-554-9136. The closest accessible BART Station is Civic Center. Accessible MUNI lines serving this location are: #71 Haight/Noriega, #9 San Bruno, F Line to Market and Van Ness, and Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. Minutes of Meeting are tentative until formally approved by the Council.

Jan Murphy - SFCC & ILS : what's going on

Mayor's HIV Health Services Planning Council
Minutes of Meeting

February 23, 1998

DRAFT

I. **Call to Order**: 4:45 p.m.

II. **Roll Call [1]**

III. **Approval of the Agenda**: The agenda was approved unanimously.

IV. **Approval of the Minutes**: Minutes from the January 26 and February 9 Council meetings were distributed, and their approval delayed until March 16.

V. **General Announcements**:

A. *JG* asked that the Council at some point discuss the letter which was faxed to its members by the San Francisco Community Clinic Consortium on February 20. He noted that although the fax specifically asked that a motion be placed before the Council, at this time only discussion of the letter's content is desired.

WC asked if all members received the fax. Several had not. *DJ* suggested that the issue be added to the AIDS Office report section of this meeting. The Council approved this addition to the agenda.

B. *WC* announced that *Tom Calvanese* is serving as proxy for *Matthew Sharp* at this meeting. He also announced that the Council co-chairs have received a letter of resignation from *Pat Christen*, in which she acknowledges the importance of this Council's charge, and explains that she is unable to make the commitment due to other demands on her time. *WC* expressed his feeling that the Council will be weakened by her absence.

C. *MC* asked if a response has been received regarding the Council's letter admonishing adequate advertising of scholarships for PLWH to attend the coming HIV/AIDS conference. The co-chairs replied that a response has not been received. *MC* offered to write a follow-up letter and present it at the next Steering Committee meeting.

D. *BC* asked when Council members who have served more than a year will be re-appointed.

Dick Pabich, Mayor's office liaison to the CARE Council, introduced himself, and explained that he recently received a letter from the Membership Committee, which listed the names of members requiring re-appointment to the Council. He plans to review that list, and the list of candidates which the Council recommended to fill the three vacant positions, next week. *Mr. Pabich* also noted that he has already interviewed some of the candidates.

TS acknowledged a rumor that the Mayor's office is trying to remove long-time Council members in favor of new ones, and expressed the opinion that the knowledge and experience of older members is important to this body. *Mr. Pabich* responded that the Mayor's office has not expressed the desire to un-seat older Council members.

E. *WC* announced that the next pre-meeting packet will contain a copy of the letter which the Membership Committee sent to the Mayor's office listing the Council's choices for new members.

VI. **Public Comment**:

F. *Dick Pabich*, of the Mayor's office, recalled that a draft report was issued after the HIV/AIDS Summit, and community members asked to submit their comments regarding the recommendations therein to the Mayor's Office. Compilation of those comments is currently under way, and will continue until early-mid. March. Those who wish to give input on the report draft, for the public record, should send it to the Mayor's office before that time.

Mr. Pabich announced that the mayor's office is currently initiating a new project called the AIDS Leadership Forum. The goal of this project is to provide planning and technical assistance to San Francisco organizations, as well as bring together the leadership of those organizations on a regular basis. The AIDS Leadership Forum will not be applied to the current RFP process, as hoped, because it is not ready for implementation.

Finally, *Mr. Pabich* noted a concern which was raised during the summit that greater communication is needed between researchers and the community. In response to this, UCSF will be holding a monthly briefing, open to the public, on HIV/AIDS research occurring within that institution.

Mr. Pabich can be contacted at (415)554-5960.

B. *Gladys Sandlin*, of the Mission Neighborhood Health Center, noted that her organization is a member of the SF Community Clinics Consortium, which collectively created a letter admonishing the Council to remove primary care services from the current RFP. She explained that the letter was born out of concern for patients, and fear for possible disruption of services. *Mrs. Sandlin* noted, however, that this letter may have been developed

hastily, and with a lack of information. She asked that the Council note the Consortium's concern, and communicate with its members to find a solution which satisfies all parties involved.

C. *Hank Wilson*, of ACT UP Golden Gate, informed the Council that he attended the Mayor's HIV/AIDS Summit, and was glad that the importance of community involvement was acknowledged. He admonished the Council to communicate to the Mayor that the enormous amount of time and energy contributed by members of the public must be recognized and valued, and community involvement sought at all levels of the system and in all decisions. Regarding the RFP, *Mr. Wilson* expressed the opinion that the Council made a strong attempt to further the integration of HIV/AIDS services, and that this RFP will be a catalyst for much-needed change.

D. *Joseph Elsen*, of the Haight-Ashbury Free Medical Clinics, expressed concern regarding the RFP. In particular, he queried why funding for primary care was not put out to bid, while non-profit primary care funding was. He expressed the fear that his act will limit patients' options for primary care providers, and destroy client-provider relationships in the community. *Mr. Elsen* asked that primary care be omitted from the RFP, but attention be given to the need to move that system toward integration.

E. *Lisa O'Connor*, PLWH and employee of Waldenhouse, expressed concern regarding some of the agencies whose funding has been put out to bid in the RFP. *WC* asked that her concern be re-raised in the RFP update section of the meeting.

F. *Lara Sallee*, of the Haight-Ashbury Free Medical Clinic and Contractors Association, spoke on behalf of *Jim Illig*, who is the president of the association and was unable to attend this meeting. *Mr. Illig* wished to convey the Contractors Association's support for the letter developed by the SF Community Clinics Consortium, including its recommendations regarding primary care. While in support of service integration, the association is concerned that the scope of change outlined in the RFP is too great to effect in the time given, and could result in disruption of services.

G. *Michael Loro*, PLWH, noted that the RFP encourages providers of peer advocacy to hire PWAs, and suggested that this encouragement be extended to treatment advocacy services as well. Secondly, Mr. Loro recalled that at the recent Contractors Association meeting the association was updated on current efforts to apply the Sunshine Ordinance to all non-profit organizations in San Francisco. He noted that input on the issue from parties other than executive directors would have been useful.

H. *John Caravantes*, client of Clinica Esperanza, expressed concern regarding possible disruption of primary care services resulting from the RFP. He stressed the importance of these services, and of the relationships which clients form with their providers.

I. *Mark Pierce*, of St. Mary's Medical Center, expressed concern regarding the inclusion of primary care providers in the integrated service model, as required by the RFP. He noted that this is the only service category in section one of the RFP which is not also included in section two, and suggested that it be included in both. In this way integration of primary care services could be treated as a pilot, to be bid on by a few providers, and the model they develop spread throughout the rest of the system over the next few years.

AIDS Office Report:

Michelle Long Dixon, of the AIDS Office, distributed a HRSA newsletter (which was sent to Council members via the AIDS Office), the Bidders Conference minutes, and an updated RFP timeline. She reviewed the RFP timeline, noting that the contractors' response deadline has been extended by one month in response to concerns expressed by providers at the February 9 Council meeting. The AIDS Office still anticipates that developing contracts will begin between July 1 and September 1. *MLD* noted that the revised timeline was sent to all who attended the Bidders Conference and/or requested copies of the RFP.

WC suggested that a discussion of the RFP, and particularly the modifications proposed by the San Francisco Community Clinic Consortium, be held at this time, and the REGGIE report delayed until afterward. The Council and REGGIE presenters accepted this suggestion. *JR* asked if the RFP discussion would have a time limit. *WC* replied that a time-check will be made after 15 minutes, and reminded Council members to announce applicable conflicts of interest before entering into the conversation.

RFP Discussion:

BC referred to the letter distributed by the SF Community Clinic Consortium, and expressed discomfort regarding its implied funding suggestion to the AIDS Office. He recalled that the Council devoted significant time and energy to the prioritization process that informed the RFP, which is de-valued by the letter.

JG, executive director of the SF Community Clinic Consortium (and Council member) announced his conflict of interest as a contractor and author of the letter. *JG* noted that the letter was not intended to offend the Council in any way, and apologized for any offense taken. He explained that the letter represents a response of primary care providers to the negative impact that they feel the RFP will have on their clients, and in no way aims to be divisive

or to belittle the work of the Council. He also stressed that the recommendations presented in the letter should be interpreted as a demonstration of concern for the client population, and used as a starting point for discussion of the reasons for concern, and what may be done to allay the discomfort.

JG also apologized for his low attendance of Council meetings during the prioritization process, which may have, in part, led to the primary care decisions to which he and those he represents object. As the sole Title III grantee in San Francisco, it is difficult for the Consortium to find representatives able to attend the Council meetings, but a replacement for *JG* will be recommended. In closing, *JG* announced that he will not forward the Consortium's suggestions as a motion, but would like the Council to consider and discuss them, and particularly to note providers' concern regarding possible disruption of primary services and patient-provider relationships.

TS spoke in support of the Consortium's proposal to delay the primary care section of the RFP, and reiterated the fear that, otherwise, primary care services will be disrupted, patient-provider relationships will be hurt, and movement from one organization to another will prove devastating to clients. To the AIDS Office staff, *TS* noted that complementary health care is included within the primary care category, and that small providers in that sub-section (such as the Immune Enhancement Project, which he represents), are being forced to initiate collaborations in ways better suited to larger, non-complementary primary care providers.

LT stated that she has a conflict of interest in this discussion, due to her employment by a current Ryan White contractor. She noted that Council members must be aware of the Council's purview and responsibilities, and those of the grantee. The Council sets service priorities and directs the proportion of funding to be allocated to each. It does not have authority over the RFP process, which is the responsibility of the AIDS Office. In the last prioritization process, the Council directed a restructuring of the delivery system toward integration. This restructuring necessarily involves pulling some contracts and putting their funding out to bid for a different type of service delivery. The Council will review the RFP in its evaluation of the grantee, but RFP writing, RFP issuance, reviewing contract proposals, etc. are not within the purview of this body. Nor can the body discuss the situations of specific contracts, as affected by the RFP.

WC observed that a large percentage of the CARE Council members have HIV, including two of the three co-chairs. He recalled that the Council underwent a long and involved process to develop its directives to the AIDS Office, including extensive solicitation of community and provider input. The Council is aware that the HIV epidemic in San Francisco is not static, and that the service system must evolve to best address the changing needs of its changing target populations. The modifications to that system, as directed by the new RFP, were judged by this body to be the best way to respond to the dynamics of HIV in San Francisco. *WC* expressed incredulity that providers would think that this Council, with its extremely high PLWH representation, would create a model that directs the dismemberment of some of this city's most prized systems. He reminded those present that, while risk is inherent to change, so is opportunity, and expressed the opinion that the opportunity presented by these changes far outweighs the risk.

JG noted that, during the prioritization process, the Council received community input mainly from those who were not receiving a service, or who were dissatisfied with the services received. These testimonies are very important, but it is also important to remember that if no complaint is presented regarding a service then the service is probably well-delivered. He recalled that the Council did not seek input regarding primary care during its last prioritization process, although he offered to organize public testimony on the subject.

JG expressed disagreement with the assertion that the only way to effect significant change in the system is to dramatically reorganize funding. He noted that the suggestions forwarded by the SF Community Clinic Consortium attempted a compromise between the stagnancy of past years and the complete renovation of this year. *JG* also reminded the Council that those suggestions did not include specific preservation of the providers involved, or contract-level detail. Thus the recommendations were made in a way that should place them within the purview of this body.

DJ reiterated *LT*'s reminder of the Council's responsibilities and limits, vs. those of the grantee. She noted that the Council is attempting to turn prioritization into an ongoing process this year, including continuous communication with the community and providers, and assessment of the effects which Council decisions have on those entities. The concern which providers have expressed regarding interruption of primary care services will be considered in this ongoing process. In addition, the AIDS Office will be evaluated with an eye to its responsiveness to provider input throughout the RFP process.

SL expressed the opinion that the providers' response to the RFP is a natural part of the entire process, and that it calls to the Council's attention the need to clearly express its intent regarding primary care. He also noted that the amount of primary care funding which has been put out to bid is only a small proportion of the total. *SL* recalled

that in the past the Council operated with an understanding that only a certain amount of DPH funding can be shifted. He asked if that originates from a formal agreement, and if it is still true.

Michelle Long Dixon replied that the CARE Council and AIDS Office have historically had an informal agreement that the DPH receives roughly 30% of this EMA's Ryan White funding. The current RFP reduces that amount to 25%. Regarding the issue of transition, AIDS Office staff which developed the RFP were aware of the difficult transitions which the document necessitated, and offered contractors 1-4 months of transition time in order to allow those changes. In return, the AIDS Office has asked that as contractors receive extensions, they submit written work plans for the extension time to the AO. The AIDS Office has had experience with such transitions, on a smaller scale, and found that contractors have a very high degree of integrity in terms of assuring continued quality care to their clients. The scope and magnitude of change to occur this year will become clear through the application review process, and the AIDS Office is committed to helping providers make those transitions in a way that will most benefit clients.

JG noted that providers need to spend their time and resources delivering services, not developing transition plans. He suggested that technical assistance funding be used to create a coordinated primary care system, rather than putting part of the system out to bid and requiring the providers involved to work out their own plans, under duress. *JG* also noted that the Mayor's MOU with the union may not allow funding to be directed back to non-profit organizations, once removed.

TC observed that attempts to effect significant change in any system creates fear and discomfort for all involved in that system. He expressed the opinion that the prospect of allowing the care system to remain static, as the community and epidemic continue to evolve is much more frightening. The Council observed radical change in the community two years ago, but it was unable to respond to the extent needed, which is why the modifications being made now are so drastic. He asked the Council and providers to acknowledge that the changes are difficult and frightening, but necessary.

BC expressed the opinion that the letter developed by the Consortium contains good suggestions, and recommended that the Consortium itself look into implementing them. *JG* responded that it is already doing so.

WC closed the discussion, noting that the concerns and recommendations voiced at this meeting will be discussed at the next Steering Committee meeting. He thanked providers for their participation and willingness to discuss concerns with the Council, and the entire group for the level of understanding and respect maintained throughout this discussion.

REGGIE Update

Jan Gurley, of the Community Health and Safety branch of the AIDS Office, introduced herself and began her presentation with a brief history of the REGGIE system. REGGIE began in 1995 with a study of the HIV/AIDS system of care, which was entitled "Voices of Experience". This study compiled client input on the system, and specifically how it could be made more client-centered. One of the most common comments given was that too much time and energy is spent on registration and paperwork, and providers should be linked in some way to create a cohesive referral system so that clients do not have to complete the same intake process numerous times. From the provider standpoint, CARE funding was reported to be dispensed without adequate planning and support for the infrastructure of the organizations to which it was given.

In 1993 San Francisco was awarded funds to develop a uniform reporting system (URS) for HIV/AIDS services. The system which was created failed because it was difficult for providers to use and they did not benefit from its implementation. However, the federal government continued to call for client-level reporting.

Because of this perceived need for coordination of client information, the CARE Council decided, in its five-year plan, to create a centralized registration system. This system, called REGGIE, has been designed with the following goals: to be de-centralized, have high security and confidentiality, to allow client choice in sharing of data, to be user friendly, and to include information and referrals.

The overall project plan for REGGIE spans five years, and includes three distinct phases. The first of these, termed the "alpha" phase, was designed to test the concept and its acceptability to clients and providers. After a number of studies conducted to ascertain the reception which REGGIE would receive in the service system, it was determined that the program would be successful in reaching its goals.

The second, "beta" phase of the plan, was designed to develop the final software for the REGGIE program. This was followed by the final phase, which is currently under way, during which the program is to be installed throughout the service system. One of the largest differences for providers using the REGGIE system will be that it facilitates client-level reporting, rather than the aggregate reporting which is most common. A goal of this stage is to create group ownership of data responsibilities; i.e. all agencies involved contribute to the client database and access data entered by one another (although there are many safeguards regarding what organizations can access

which information). This phase also includes a continuous quality improvement process, to ensure that the data contained is always accurate.

Jan displayed an overhead projection outlining the three phases of REGGIE implementation, and how each has been funded. Several funding sources have supported this project: CARE admin. dollars, CARE service dollars, General Fund, grants and donations. *Jan* noted that the Council has proposed a tentative $180,000 award to REGGIE for the coming year, which is not yet certain. Because the federal government has in the past directed that a proportion of the CARE service dollar award be taken from CARE admin. funds, if this $180,000 is allocated to REGGIE it is likely that only about $140,000 will be service dollars.

As designed, REGGIE allows clients to choose what, if any, of their information can be accessed by organizations other than the one which conducted the original intake, and which organizations have that access. Also, patients can enter the system anonymously. As another security measure for client protection, information regarding substance abuse and mental health are not shared between providers, even with client permission.

REGGIE has been designed to be as user-friendly as possible, and flexible enough to meet the specific needs of any organization. The program also includes several security measures which insure that only authorized providers can access information, and only the information which each is approved to access.

Benefits to agencies include billing functionality, fulfillment of all reporting requirements, a support system for users and quality assurance measures.

Benefits to the CARE Council include more leverage in the re-authorization of Ryan White funding due to greater reporting abilities, ability to use the system to provide needs assessment information, and availability of planning data.

Jan outlined the REGGIE timeline plan, which includes enrollment of all applicable organizations by December, 1999.

Questions and Discussion

MC asked what is the projected cost to maintain the REGGIE program, once installed. *Jan* replied that technical consultants and outside evaluators estimated the yearly cost to be $400,000-500,000. This includes salary support, which is currently paid by General Fund. In the future, at least one more technical support staff member will need to be hired, and another epi. data evaluation member as well.

JG asked if agencies using REGGIE will require additional technical support. *Jan* explained that system conversion is very disrupting to agencies, but the resource which they will use most in that conversion is time. Agencies should not need to hire additional technical support, but will need time to train current staff in use of the new system. Enrollment with REGGIE will include an agreement that the REGGIE project covers the costs to set up the program, and agencies will pay for its continued use.

WC asked *Michelle Long Dixon* if REGGIE charges incurred by providers will constitute a soft cost for CARE. She replied that they will. *WC* informed the group that he was originally a member of the REGGIE task force. He asked how far into the five-year plan is the REGGIE project currently, and the total cost for the full five years. *Jan* replied that this is year 3, and that the total cost will be about $2 million, roughly 20% of which will be from CARE. *WC* asked how much of the $2 million has been spent to date. *Jan* replied that $200,000-300,000 remains at this point. *WC* asked how the project will be funded for the two years remaining in the plan. *Jan* explained that the program has been aggressively diversifying its funding sources in order to obtain the amount needed to complete the project. Most funding has been obtained from sources other than CARE, and the staff involved has made a conscious effort to tap into other avenues for support. *WC* recalled that REGGIE has requested $180,000 this year, and asked if more will be requested in the coming years. *Jan* replied that that it unknown, and will be avoided if possible. She added that the extent to which CARE supports this project also depends on the Council's view of it. If awarded, the $180,000 funds for this year will be used to buy hardware. *WC* asked how many sites currently use REGGIE. *Jan* replied that two organizations currently use it, but many more will be enrolled in the next five months. *WC* suggested that Council members and public with questions about the program contact the REGGIE program and receive written responses, to be referred to the Council.

DJ thanked *Jan* for her presentation, and noted that it will be invaluable in the Council's process of deciding if and how to support REGGIE. She asked if the proposed $180,000 is to take effect this year or next. *WC* recalled that the Council tentatively allocated REGGIE $180,000 for this year, with the condition that information about the program be provided to the Council and verification from the Council be required before funding is definite. He suggested that the Council vote on that funding at one of the March meetings.

BC asked how many people are expected to be served by REGGIE. *Jan* replied that it is unknown how many clients are served by CARE in any category, and therefore impossible to conjecture the number which would benefit

from this program. At the last count, the URS project was reporting on 8,000 clients, which includes only fourteen of the seventy organizations which will eventually use REGGIE.

TC asked that further questions be addressed to *Jan Gurley* through *Veronika Cauley*, who is a member of the REGGIE Policy Committee. *VC* explained that she is in the REGGIE system and confident that her information will be kept confidential unless she authorizes its release.

Jan distributed a handout entitled "REGGIE: Connection to CARE", copies of the REGGIE registration form, and the " DRAFT Registration Form Companion".

IX. **Unexpended Funds Update**

Michelle Long Dixon informed the Council that the entire $275,000 in unexpended funds have been allocated to emergency financial assistance, as directed by the Council at its meeting on February 12.

X. **Committee Reports**

A. **PWA Caucus:** *TL* distributed a document entitled "Draft Position Statement on Agency Staff and Boards", and explained that it relates to a policy recommendation presented to the Council by the PWA Caucus in February. The recommendation had been to gather information about PLWH involvement in all levels of the service system, and was rejected and referred back to the Caucus for further development. This document is the Caucus' response to Council input on that recommendation, the main modification being that the information requested will focus on level of participation within the organization, rather than specific position. The levels outlined in the proposal are volunteer, staff/ support, management and executive-level positions and board members. Another change made to the proposal is the addition of the sentence "Information will be collected and utilized in accordance with all applicable laws concerning confidentiality".

JG clarified that this proposal relates to reporting requirements, not contract language. *TC* replied that this is a policy recommendation to the AIDS Office. *LT* noted that once a policy recommendation is made to the AIDS Office, it will be carried out as the office sees fit. This may mean inclusion into contracts, which is not a Council decision. *JG* expressed concern regarding a possible requirement that providers ask employees to self disclose. *TC* replied that past Council discussions of this issue have clarified that only those who are already self-disclosed are to be asked, and then only to verify whether they want to disclose for the purposes of this data collection.

TL recalled that this proposal was born out of the PWA Caucus' desire to assess involvement of PLWH at all levels of the service system. The proposal is to instruct the AIDS Office to collect that information from contractors, for review by the Council, but does not address how that data should be collected.

MC called a question. **A roll call vote was held, and the motion passed 19 in favor and three opposed, no abstentions [2].**

TL announced that at its last meeting the PWA Caucus elected *Nilda Rodriguez* as co-chair, and she will begin reporting to the Council in August. He also informed that Council that the Caucus has received a grievance signed by 30 residents of Derrick Silva, which will be referred to the HIV Consumer Rights Advocate when that office is ready to receive complaints.

TS asked if this grievance should be addressed in another way, to facilitate its mediation, rather than wait for the HIV Consumer Rights Advocate to begin operation. *TL* replied that the Council still has a complaint lodged by residents of Derrick Silva, dating back to October, 1997. *TC* suggested that the issue be discussed at the next Steering Committee meeting to develop an interim mechanism for addressing grievances. *WC* asked that the Caucus research the current grievance and bring information to the Steering Committee.

Michelle Long Dixon explained that the regular AIDS Office procedure for addressing grievances is to refer them to the contract manager, who then communicates with the agency and requests a report on how the problem will be resolved.

JR expressed concern regarding the grievance which was addressed to the Council in October, and asked why it was not forwarded to the Evaluation and Assessment Committee. *TC* replied that that complaint was addressed, and the Council received a written response from the contractor, which was circulated in the correspondence file.

JG asked why complaints are being sent to a Council member, rather than its co-chairs. *TC* explained that in the past they have gone to Council co-chairs, who brought them to the Council, which frequently forwarded them to the PWA Caucus. This time the complaint was sent directly to a PWA Caucus co-chair.

KW noted that the Council should clarify for itself how grievances will be handled until the HIV Consumer Rights Advocate begins operation, because it would be dangerous to start responding to individual complaints.

TC explained that the current procedure is to refer grievances through the AIDS Office to the program manager responsible for the oversight of the program in question. It is then the responsibility for the program manager to follow up on the complaint, and either s/he or the contractor must report back to the Council, through the Evaluation and Assessment Committee. *KW* asked if all grievances addressed to the AIDS Office require reports to the Council, or only those which come to the AIDS Office through the Council itself. *TC* explained that that is unclear because in the past there has been no formal process for addressing grievances which come to the Council.

DJ introduced *Dr. Chow*, who is a member of the Health Commission. She noted that the Health Commission representative to the CARE Council, *Ron Hill*, has not been attending meetings, and that the need for that mandated seat is currently being discussed.

Dr. Chow explained that his membership on the Health Commission predates the creation of the CARE Council. He commended the Council on its hard work and good public process, and noted that the issues which it addresses are extremely important. *Dr. Chow* explained that the Health Commission is currently undergoing changes to better enable it to meet the changing needs of the populations it serves, and looks forward to working with the CARE Council in whatever capacity it can.

B. **Membership Committee:** *MC* reported that at its last meeting the Membership Committee conducted an attendance review of the fourth quarter of 1997, identifying eight members who are out of compliance with the attendance requirements adopted in October. Those members received letters informing them of the Committee's intent to recommend their removal from the Council, as dictated by the by-laws, and inviting them to speak on their own behalf at this meeting. *MC* acknowledged that individual scrutiny of members is awkward, and noted that this process was developed by the Council in 1997 with the goal to maintain high participation.

MC said that the first member to be reviewed will be *Jeff Byers*, who is not present at this meeting, nor did he submit a letter to the Membership Committee regarding his recommended termination. *MJW* noted that *JB* is on many other Councils, which affects his ability to attend regularly. She added that a state representative to the Council is very important, and *JB*'s attendance is better than other representatives that this Council has had. She therefore supports allowing *JB* to remain on the Council.

WC reminded the Council that when a member is frequently absent (for reasons other than HIV-related illness), the Council itself loses their knowledge and expertise, and members who do attend are given more than their share of the responsibility. He said that the Council commits to specific representative seats, but not specific people to fill them. He suggested that the Council ask the state to send the representative most able to attend meetings. That person may be *JB*, or may be someone else.

BC noted that *JB* has to travel to attend San Francisco CARE Council meetings, and suggested that an alternate representative be appointed for times when he is unable to attend.

MC expressed concern that *JB* did not respond to the letter notifying him of his attendance status, but noted that until the final quarter of 1997 his attendance always met the requirements. From conversations with him, it is clear that *JB* would be willing to share the position. There is currently no mechanism for sharing a seat on the Council, but the Membership Committee may discuss that possibility. *TC* recalled that the by-laws allow the state representative to appoint a proxy.

Doc made the friendly amendment that the vote be delayed until the Membership Committee discusses with *JB* his options regarding attendance by proxy, shared membership, etc. *MC* did not accept the amendment.

RT asked if the letter sent to those not in compliance with attendance requirements gave a deadline for response, or if the by-laws specify a length of time. *MC* said that it did not, but was sent at the end of January, and specifically invited members to speak at this meeting.

The Council voted the Membership's recommendation to terminate *Jeff Byers'* membership. The motion failed, 17 opposed and 5 in favor, no abstentions [3].

MC announced that the next member in question is *Virginia Cafaro*. *VCaf* noted that she did not receive the letter of notification, and questioned whether *JB* may not have, either. *MC* replied that the letters were mailed by *Eric Sorensen*, of the AIDS Office. *VCaf* explained that she joined the Council with the intention to attend regularly, but has been unable to do so due to circumstances beyond her control. She has spent the past several months establishing a private practice, which has required more time than expected. If she had been prepared for the time commitment necessitated by that endeavor she would have requested a leave of absence from the Council for that time period, but at this point it appears she will be able to begin attending again. She asked to be allowed to remain on the Council.

JR spoke in support of *VCaf*, noting that she is the first medical doctor on the CARE Council, and was the only one who expressed interest when the position was advertised. *LT* also expressed support for *VCaf*'s request to remain on the Council, and noted that her reason for missing past meetings is a valid one.

The Council voted on the Membership Committee's recommendation to remove Virginia Cafaro from the Council. The motion failed, 19 opposed and 2 in favor, no abstentions [4].

MC noted that *Carol Gong*, the next member in question, sent the Membership Committee a letter explaining that she is unable to commit to the requirement of five meetings each quarter.

LT noted that the MediCal representative is a mandated seat, and expressed the opinion that it is important to receive the input of that representative. She suggested that *CG* be removed from the Council and an attempt be made to find someone else to fill the position. *WC* asked *Dick Pabich* and *Dr. Chow* to aid the Membership Committee in finding a MediCal representative for the Council.

The Council voted on the Membership Committee's recommendation to remove *Carol Gong* from the Council. The motion passed unanimously, no abstentions [5].

MC announced that the next member to be discussed is *John Gressman*. *JG* apologized for his lack of attendance, and explained that, due to the nature of his work, he is unable to commit to the time required by this Council. He acknowledged that regular attendance is important for the process of this body, and said that he has asked his employer (as the only Title III grantee in this EMA, currently) to find another representative for the Council. *JG* suggested that he remain on the Council until the next meeting, after which he will be replaced.

VC expressed regret that *JG* may be leaving the Council, and noted that when in attendance he contributes good insight to the discussion. *WC* stated that the issue raised earlier around the inclusion of primary care CBOs in the RFP demonstrates the importance of Title III representation on the Council. He agreed with *VC* that *JG*'s input has been valuable in Council discussions, and expressed regret that he is unable to make the time commitment.

DJ asked that the Title III grantee refer the Title III replacement to the Membership Committee for review before s/he is appointed. *JG* replied that it will.

TL moved to postpone the vote on JG's termination. The motion was seconded and passed by voice vote (unanimous).

MC said that *Ron Hill* is also in violation of the attendance policy. *Dick Pabich* announced that he spoke with *RH*, who said he had resigned. *MC* replied that the Membership Committee received no communication from him. The Council agreed to accept his resignation, as stated by a Mayor's Office representative.

The next member in question is *Carmen Portillo*, who did not attend this meeting, or initiate communication with the Membership Committee.

MJW expressed appreciation for *CP*'s input, when present, but noted that this is the second time she has been out of compliance with attendance requirements. For that reason, she expressed support for the Membership Committee's recommendation to remove *CP* form the Council.

The Council voted on the Membership Committee's recommendation to terminate *Carmen Portillo's* membership. The motion passed unanimously [6].

MC announced that the final member to address is *Nilda Rodriguez*. *NR* apologized for her poor attendance, and noted that she did ask *Eric Sorensen*, of the AIDS Office, to inform *Norm Nickens* of her inability to attend. Her lack of participation has been primarily due to illness and job-related issues. *NR* asked to be allowed to remain on the Council.

TC expressed support for *NR*'s request, and noted that she is a PLWH, and had health problems when the Council was in the process of instituting a proxy system for PLWH. He also expressed the opinion that the orientation process through which *NR* was trained was insufficient, and her commitment to the Council is demonstrated in her willingness to co-chair the PWA Caucus. *TL* expressed his agreement, and noted that *NR* has been very valuable to the PWA Caucus. *MC* added that the Membership Committee is working on its orientation process, which has not sufficiently welcomed and acclimated new members to the Council and its process.

KW suggested that better communication be fostered between the AIDS Office and Membership Committee, and that the Council remember the leave of absence option for members unable to attend for a period of time.

A roll call vote was held on the Membership Committee's proposal to remove *Nilda Rodriguez* from the Council. The motion failed unanimously, one abstention [7].

MC announced that *Marianna Balquiedra* has requested a six week leave of absence. The Council held a voice vote and the request was approved unanimously.

MC asked all Committees to submit to him the information they wish to contribute to the new member orientation process as soon as possible. He also reminded committee chairs to submit their attendance records.

TC asked *MC* to send letters to the members whose continuation on the Council was just voted on, informing each of the outcome and thanking them for their participation.

JC asked that in the future the Council discuss the procedure for addressing attendance problems, and expressed the opinion that the process followed at this meeting, although developed and approved by the Council itself, was inadequate. *TC* expressed his agreement, and asked *JC* to bring his concern and suggestions to the Membership Committee.

BS suggested that Council members inform *Emily Coles*, who takes the Council minutes and keeps the attendance records, instead of *Eric Sorensen,* when they will miss a meeting. *EC* can be reached at (415)777-3229 ex.313 (this number is also listed at the end of every set of minutes).

GG noted that many Council members regularly arrive late to meetings, which affects agenda items requiring quorum and often forces meetings to run later than scheduled.

JR clarified for the Council that informing *Eric Sorensen* or *Emily Coles* in advance of an absence does not negate that absence.

DJoe asked the Council co-chairs to address the problem of AIDS Office mailings reaching members late, or not at all. The co-chairs replied that they are working on it.

Regarding the process used to address non-compliance with the by-laws, *MC* explained that it is clearly stated in the by-laws, and so although he finds it an uncomfortable process he was responsible for the Council's adherence to it. He agreed that the process should be modified.

DJ informed the Council that this meeting was moved to 25 Van Ness Ave. due to a scheduling conflict at the usual room at SFAF, not due to *Pat Christen*'s resignation from the Council. *LT* explained that today, and for several more Mondays, the room at 10 United Nations Plaza has been reserved for SFAF treatment education meetings. *DJ* reminded Council members to note the location of each meeting in their pre-meeting packets, because the Council is currently seeking a new space.

TC announced that *Rita Times* is resigning from the Council. He thanked *RT* for her participation and commitment to the Council over the past five years. *RT* explained that her job commitment has increased significantly, making her unable to commit to the time required for Council membership.

XI. **Adjournment**: 8:05 p.m.

DRAFT

ATTENDANCE AND VOTING RECORD

P=present; A=absent; E=excused; L=leave of absence; Y=yes; N=no; B=abstain; R=proxy

	1	2	3	4	5	6	7		1	2	3	4	5	6	7
James Abrams	A							Diane Jones	P	Y	Y	N	Y	Y	N
Kirsten Balano	P							Susan Karp	P	Y	N	N	Y	Y	N
Marianna Balquiedra	L							Tony Leone	P	Y	Y	N	Y	Y	N
Jeff Byers	A							Steve Lew	P	Y	N	Y	Y	Y	N
Virginia Cafaro	P	Y	N	N	Y	Y	N	Norm Nickens	L						
Tom Calvanese	P	Y	Y	N	Y	Y	N	Carmen Portillo	A						
William Carter	P	Y	Y	N	Y	Y	N	Ron Reynolds	A						
Bart Casimir	P	Y	N	N	Y	Y	N	Alissa Riker	P	Y	N	N	Y	Y	N
Veronika Cauley	P	Y	N	N	Y	Y	N	Nilda Rodriguez	P	Y	N	N	Y	Y	N
Michael Chesek	P	Y	N	N	Y	Y	N	Joy Rucker	P	Y	N	N	Y	Y	N
John Conley	P	Y	Y	Y	Y	Y	N	Barry Savage	P	Y	N	N	Y	Y	N
Mark Dunlop	A							Matthew Sharp	R						
Miriam Farooq	A							Thomas Sinclair	P	Y	N	N	Y	Y	N
Carol Gong	A							Laura Thomas	P	Y	N	N	Y	Y	N
Gene Gowdey	P	N	N	N	Y	Y	N	Rita Times	P	Y	N	N	Y	Y	N
John Gressman	P	N	N	N	Y	Y	N	Brett VanBenschoten	A						
Dee Hampton	A							Kelly Wallace	P	Y	N	N	Y	Y	N
Ron Hill	A							Mary Jane Wood	P	Y	N	N	Y	Y	N
Danny Joe	P	N	N	N	Y	Y	N								

Tom Calvanese served as proxy for Matthew Sharp at this meeting.

The Council meets on the first and third Monday of each month, at the time and place noted above. All are welcome and have the opportunity to comment on agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff at 554-9136. To request an excused absence (Council members only), contact Emily Coles at 777-3229. *Minutes of meetings are tentative until formally approved by the Council.*

DRAFT

MAYOR'S HIV HEALTH SERVICES PLANNING COUNCIL

March 16, 1998

SF Department of Public Health AIDS Office, 25 Van Ness Avenue, Suite 330

AGENDA

I.	Call to Order	4:30 PM
II.	Roll Call	
III.	Review and Approval of Minutes	
IV.	General Announcements	
V.	Public Comment	
VI.	Reports	
	A. PWA Caucus Report 1. RFP Panel 2. Community Input Roles for Committees 3. Follow-up on Grievance Process	5:00
	B. Membership Committee Report 1. New Members 2. Reappointment 3. Bylaws Change (Motion) 4. New Member Orientation Plan 5. Letter in Support of Barry Savage (VOTE) 6. Letter to the Mayor: New Members (VOTE)	5:15
	BREAK	5:45
	C. Housing 1. Work Plan Presentation and Report 2. Consumer Representatives - HOPWA and CARE (VOTE)	6:00
	D. Evaluation and Assessment Committee 1. Reductions Protocol (VOTE)	6:15
	E. Planning Committee Report 1. Presentation of Meetings	6:25
	F. Steering Committee Report 1. Planning Council Support (VOTE)	6:35
VII.	New Business	6:45
VIII.	Adjournment	7:00

Up-coming Meetings:

March 23, 1998 - Planning Council, AIDS Office, 25 Van Ness Ave., 3rd Floor Conf. Rm, 4:30 - 7:30 PM

San Francisco Department of Public Health, AIDS Office, 25 Van Ness:

The site is fully accessible, and assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to the Council Members, are available for inspection and copying. For further information, call the Council's staff, 415-554-9136. The closest accessible BART Station is Civic Center. Accessible MUNI lines serving this location are: #71 Haight/Noriega, #9 San Bruno, F Line to Market and Van Ness, and Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of Meetings are tentative until formally approved by the Council.*

I. **Call to Order**: 4:45 p.m.

Roll Call [1]

I. **General Announcements**:

A. *NN* announced that *Jeff Byers* will miss both CARE Council meetings in March due to job-related travel. *James Abrams* will not be at Council meetings for at least another month because he is beginning chemotherapy at Mt. Zion Hospital. *TC* asked *NN* to inform the Membership Committee of *JA*'s attendance status.

B. *MD* informed the Council that Proposition 1 will be put on the ballot in June. This proposition would require agencies receiving funding to house or serve PLWH to put signs in their windows at least 50 days prior to funding is approval. Many believe that this would have a very negative impact on housing services for PLWH, and a group is organizing to oppose the proposition. This group meets every Monday at noon, at 65 9th Street. All are welcome.

C. *NN* noted that the pre-meeting packet included a memo from him and a form from the state. Members are required to complete this form upon appointment to the Council, on a yearly basis during their membership, and upon leaving the Council. The annual submission for 1998 is due April 1, but forms must be submitted to the AIDS Office by March 25. A $10/day late fee will be charged to those who do not submit by this date. Those who need copies of the form should contact *Eric Sorensen*, and questions can be addressed to *NN* (554-2856).

D. *TC* welcomed new members to the Council and asked them to introduce themselves to the group. *Fernando Chavez* introduced himself. *Lisa O'Connor* explained that she works in HIV services at Waldenhouse, is a recovering addict and has been living with HIV for over 8 years. Lisa has a newborn daughter. *Loras Ojeda* introduced himself.

TC announced that the Council mailing list is being updated. A list will be circulated at this meeting for members to denote address changes, corrections, and add e-mail and fax numbers if possible.

I. **Approval of the Minutes of January 26 and February 9**: *MD* moved to approve the minutes from January 26. The motion was seconded. The minutes were approved with three abstaining and none opposed. *LT* moved to approve the minutes of February 9. The motion was seconded and the minutes approved with four abstaining and none opposed.

II. **Public Comment**:
TC opened the meeting to public comment, and asked community members to limit comments to two or three minutes. He noted that public comment will be taken again before votes.

Kavan Hughes, AIDS researcher and student, explained that he has been conducting research in the field of AIDS for ten years, and has hosted two talk shows on channel 53. Through his research *Kavan* has traced the HIV virus back to 1932, when it was first discovered by *Dr. Sabath.* He expressed the concern that many AIDS service organizations are currently being funded by those who invented HIV, and frustration that the issues of how and why HIV became a global epidemic are not being adequately addressed. *Mr. Hughes* announced that soon he will address this concern to the United Nations, which is the organization he believes to be responsible for the HIV epidemic.

TC thanked *Mr. Hughes* for his input, and asked for further public comment. None was offered. He noted that the PWA Caucus chair, who is scheduled to give a report at this time on the agenda, had not yet arrived, and suggested that the Membership Committee report be presented next, followed by the PWA Caucus when its chair arrives. The Council agreed.

VI. Membership Committee Report:

Reappointments and Letter of Support for Barry Savage
MC noted that all members should have received letters of reappointment except *Barry Savage. MJW* said that she has not received a letter. *MC* explained that at the Membership Committee meeting on March 9 it was decided, upon *BS*' request, to propose that the Council submit a letter of support for his appeal to the Mayor for reappointment. *MC* read a letter that was drafted for that purpose. The letter asks the Mayor, on behalf of the CARE Council, to reconsider the omission of *BS* from the list of reappointees for 1998, and explains that he has been an asset to the group and his continued participation is desired.

JR asked if it is known why *BS* was not reappointed. *MC* replied that he has not been given a clear reason. *Dick Pabich*, of the Mayor's office, explained that the Mayor's intent was to keep three seats open on the Council in order to recruit additional expertise and allow for a larger pool of nominations. Originally, a greater number of seats were to be opened, but at the request of the co-chairs the Mayor was persuaded to reappoint across the board. At this point there are three mandated and three unmandated seats open. *Mr. Pabich* noted that the decision not to reappoint

BS was not based on him personally, but on the lack of information that has been submitted about him, and the desire to increase the number of vacancies on the Council. However, this decision could be reconsidered.

After the discussion of new members (next section) *DJ* reiterated the proposal to support the letter urging *BS'* reappointment to the Council. *LiO* asked if new members should abstain. *DJ* replied that they may, but are not required to. A voice vote was held and the motion passed without opposition, four abstaining.

New Members

MC listed the four new members who were appointed from the list of seven that the Membership Committee submitted to the Mayor's office: *Fernando Chavez*, *Loras Ojeda*, *Lisa O'Connor* and *Troix Bettancourt*. *Leanne Monferdini* has been recommended to replace *Ron Hill* as the Health Commission representative, but the Committee is still awaiting her nomination form. *MC* noted that the Membership Committee's records do not show six open seats on the Council at this time (including *BS*' seat), and asked *Dick* to compare records with him outside of the meeting. Of those recommended for appointment, *Chris Bohm*, *Dorothy Bartolomucci* and *Johnnie Norway* remain, and it is the intent of the Membership Committee that they be chosen to fill open seats before further nominations are accepted.

WC distributed a letter that the Membership Committee asked him to draft. This letter addresses the Mayor's office regarding the membership process, particularly as it pertains to appointments. He explained that the letter is intended to clarify the appointment process, and especially HRSA guidelines on how that process should be structured. The letter also requests that the nominations forwarded to the Mayor's office by the Membership Committee be honored, and notes that the Council followed a careful process in choosing those applicants. *WC* stressed that the intent of the letter is not to circumvent the grantee's ability to appoint Council members, but to explain how the Council arrived at the nominations it forwarded to the Mayor and how the Mayor's office must include the Membership Committee in its own nomination process. He asked members to read the letter and give him feedback as soon as possible, and suggested that a vote be held on Council support for the letter at its next meeting.

TC added that after reviewing many impressive applications the Membership Committee chose seven candidates who it thought would greatly benefit the Council in terms of their experience and representation, and asked the Mayor's office to fill the next seven vacancies from that list. He recalled that the last time applications were accepted the Council was lacking HIV+ women, youth and Latinos, and that the only criticism that HRSA submitted last year regarding this body and its process was the lack of Latino representation.

Dick Pabich noted that he has discussed issues of membership and appointment with *MC* and the Council co-chairs, and added that the Mayor's office is aware of the need fill the vacant seats as soon as possible. He reiterated that three seats were left open in order to recruit greater expertise, and suggested that the application process be re-opened since it was last conducted many months ago. The Mayor's office is at this time particularly interested in finding applicants with experience in mental health, research, children and families, and CARE legislation at the federal level. These representations were chosen based on input from the Mayor's HIV/AIDS Summit regarding fields with which CARE services should develop greater linkages, and the recent resignation of *Rita Times*. *Dick* noted that he discussed these representations with the Council co-chairs, and was under the impression they agreed with his direction.

Mr. Pabich apologized for the misunderstanding regarding the Health Commissioner representative, and said that Leanne Monferdini's application will be accepted. He has also submitted his own application for consideration. *Mr. Pabich* explained that the Council's request that all members be reappointed, and only those applications which it forwards to the Mayor's office be considered, provides the Mayor with no discretion regarding the membership of this body, which was not the intent of the federal guidelines. He also reiterated his opinion that Council vacancies should be advertised again because several months have elapsed since applications were last accepted. The Mayor has requested a demographic breakdown of the current Council membership, which *Mr. Pabich* has not been given, in order to inform the appointment process. In closing, *Mr. Pabich* promised to do what he can to expedite the appointment process.

MC noted that there are several reasons why the last appointment process was slow, including the Mayor's involvement in the HIV/AIDS Summit. He explained that normally the Council advertises openings when it perceives gaps in representation. At this time the Council has not identified such gaps, and beginning another application review process would delay the appointment of new members at least two months, while three applicants have already been identified by the Council and are awaiting appointment. *Mr. Pabich* asked if the resignations of *Rita Times* and *Pat Christen* present gaps in representation.

DJ suggested that this conversation continue at the next Membership Committee meeting, which will be **April 3 from 9:00 to 11:00 a.m.**, and asked *Mr. Pabich* to attend that meeting. He agreed to do so, and noted that the seven applications forwarded to the Mayor's office were all very impressive.

LT noted that the Council does need to consider the representation and expertise that have been lost through recent resignations. She suggested that the Membership Committee and Mayor's office work to develop a list of

representations, in terms of both demographics and experience, which the Council should include. *LT* also expressed concern regarding the timing of the appointment process, and the problem presented by appointing new members just before the bulk of the prioritization process begins. She suggested that the Membership Committee meet before April 3 to address this concern. *DJ* noted that anything decided by the Committee has to be approved at the Council, which won't occur before its meeting on April 20.

TC asked when the seven applications were sent to the Mayor's office for appointment. *LT* said they were sent in January. He asked the Council to recognize that the Membership Committee is doing its job well, and empower the group to continue.

Proposed Bylaws Change

MC reminded the Council that the Brown Act requires proposed bylaws changes to be on the table for 30 days before approval or rejection. Thus at this meeting he will summarize the changes that the Membership Committee proposes and answer clarifying questions, but discussion and voting on those changes will occur in April. The changes are: 1. addition of language allowing the state representative (*Jeff Byers*) to appoint an alternate to attend Council meetings in his stead, when necessary 2. modification of membership categories to match those outlined in the legislation and 3. creation of term limits for Council members.

TC opened the floor for questions on the proposed bylaws changes, noting that the discussion of their content will take place in April.

NN suggested that Committees discuss the proposed changes and bring their questions to the first Council meeting in April.

TC explained that the language regarding alternates for the state seat is proposed in recognition of the fact that it is difficult for that representative to attend all Council meetings, and his viewpoint is an important one to include in Council discussions. The second change, regarding membership categories, was discussed last fall, and delayed. *TC* explained that the modification shown on page 2, section 2 of the document included in the pre-meeting mailing, is addition of the new language in the CARE Act concerning membership categories. The first sentence of that section, beginning "Membership shall reflect..." is directly quoted from the CARE Act, while the next sentence was added by the Membership Committee to specify who will ensure compliance with that clause. Changes suggested for the membership category list are intended to make that list more inclusive and representative of the community. *TC* noted that it was difficult to remove some of the categories that the Council voted to add in the past, but that the Membership Committee has shown its intent to make this Council representative of the community, and should be trusted and empowered to do so. *MC* added that omission of some categories does not reflect a belief that they are unnecessary, but that the Membership Committee will reassess the category list every six months to insure continued reflection of the community this body serves.

Dick Pabich asked if the language regarding term limits can be discussed at this meeting. *MC* suggested that recommended changes to the proposed language be brought to the Membership Committee meeting on April 3, when the Committee's proposals will be finalized. He added that some membership categories may need to be added in order to comply with Title II legislation. At the top of page 3 a paragraph regarding termination of members was stricken because it was redundant (the same information is contained in article 6). *MC* explained that the change in section 3, setting term limits, is proposed in response to concern voiced by community members regarding length of Council membership. He noted that because some members have already served on the Council for more than three years, the group must agree on how to proceed if the change is approved. He distributed a motion, to be voted after the bylaws proposals, which states that members who have served more than two years shall submit their resignation within one year of the passing of the motion. According the Membership Committee's records, there are currently 11 members who have served over two years. *MC* explained that if this motion passes the Committee will help coordinate resignations so that they are not submitted simultaneously.

Mr. Pabich asked if the intent is to create three-year terms or allow three one-year terms. *MC* replied that the intent is for members to serve three years.

MC explained that another proposed bylaws change is rearrangement of the articles to follow a more logical order. This rearrangement is reversal of the article on membership and purpose, so that the Council's purpose is first. Finally, the Committee proposes that attachment A be modified to bring it in line with the bylaws changes made last fall.

New Member Orientation

MC distributed and reviewed the new member orientation plan developed by the Membership Committee. This meeting will include a description of the CARE Act, roles and responsibilities of Council members, structure of the Council, attendance requirements and leave of absence procedures, descriptions of the subcommittees, overview of the prioritization process, description of service categories, basic information on the organization of services in the EMA, an outline of the AIDS Office-CARE Council relationship, explanation of the mentoring program, welcome and food. The orientation will be one three-hour session with an outside facilitator, who has not yet been identified. *MC* invited all Council members to contribute to the orientation process. He added that within two weeks of

appointment all new members will receive informational packets, and any of the current new members who have not yet received the listed documents should notify him.

KW said that he had not realized the bylaws were being revised, and would have liked to be involved sooner in the process. He asked if the Council was notified that that process was occurring in the Membership Committee. *TC* agreed that it should have been announced in a previous Committee report, although the Council decided last fall that bylaws would be re-examined early this year. He noted that discussion of the proposed changes will occur at the April 3 Membership Committee meeting, and again at the full Council meeting on April 20.

VII. **PWA Caucus Report** (fully documented in a handout distributed by *TL*):

Community Input

TL reminded the group that the Community Input Committee was dissolved early this year, with the intent that soliciting input become the job of the Council and all its subcommittees. The PWA Caucus has accepted the responsibility of coordinating the collection of community input, but in order to do that it needs to know what each Committee plans to do. To that end, the PWA Caucus is requesting that each group develop a work plan for gathering input this year.

RFP Review Panels and Monitoring Teams

TL reported that the PWA Caucus has compiled a list of PLWH who are interested in joining RFP review panels and monitoring teams. This list has been submitted to *Billy Pick*, at the AIDS Office, and an orientation is being developed. *TL* encouraged Council members who know interested PLWH to refer them to himself, *NR* or the AIDS Office to participate in the orientation.

Grievance Petition Follow-Up

TL recalled that the grievance petition received in October, 1997, from Derrick Silva residents was reported to have been resolved. He said that he spoke with some of the signers of that petition, who said that they were not informed of a resolution, and their complaints were not resolved. *TL* explained that internal communication about the petition was lacking, and the result was that no one was told how it was handled. The PWA Caucus will work on that process to improve communication and ensure that petitioners are informed of the resolution.

TL noted that the packet distributed also contains the 1998 PWA Caucus work plan, which is subject to modification. He noted that the Caucus plans to work with the Membership Committee on a buddy/mentoring program for new Council members, and that it recently received a request from the Executive Director of Shanti for the Caucus co-chairs to attend that organization's Board of Directors meeting on March 24. They are unable to attend that date, so another meeting was set for April 18.

DJ asked why Shanti asked the Caucus co-chairs to attend a board meeting. *TL* explained that Shanti wants to know what issues the Caucus is addressing so it can consider how they apply to that organization and how its services can be improved. Caucus co-chairs, in turn, want to dialogue with providers to hear their current issues and concerns.

BC said he had thought the list of people interested in serving on RFP panels would be presented to the Council before referral to the AIDS Office. *TL* explained that what the AIDS Office has been given is a list of PLWH who have expressed interest in the process. It is not a recommendation to the office, because the AIDS Office itself decides who to train and who will serve.

LiO asked how Council members should proceed when they know of someone who would be interested in joining an RFP review panel. *TL* explained that they should give names to *NR*, PWA Caucus co-chair, or *Billy Pick*, of the AIDS Office.

NN asked if the PWA Caucus plans to provide a mentoring program to new PLWH on the Council, to be coupled with the program that the Membership Committee will provide for all new members. *TL* replied that the programs will be identical, but the Caucus wanted to be involved in its development. He explained that he and *MC* have not yet discussed the mentoring process, but his concept was that new members who already know someone on the Council will couple with that person. Then for their first three months on the Council the new member has someone to ask for background information, clarification, etc., so that time is not taken during Council meetings to answer those questions. *MC* added that the PWA Caucus will probably take over the new member mentoring process eventually, so that it is not split between two Committees.

JC asked if those who have expressed interest in serving on review panels are willing to serve outside San Francisco. *TL* replied that they will be used in San Francisco first, the effectiveness of this method of identifying and training panel members will be assessed, and then those able and willing to serve in other counties will be identified. Other counties' review processes will also have to be examined to see how they could utilize those panel members.

The **PWA Caucus next meets April 1, 5:00-7:00 at 25 Van Ness Ave.** *NR* will chair that meeting and give the report at the subsequent Council meeting.

VIII. **Housing Committee:**

Work Plan Presentation

TC reported that at its last meeting the Housing Committee reviewed housing recommendations made by the Council during the 1997 prioritization process to assess which are addressed in the current RFP and which will be addressed through other processes, such as contract revision. A list of the latter was compiled by the Committee and submitted to *Louis Sands*, of the AIDS Office, who is overseeing their implementation. The Committee has also created a 1998 work plan, which will be distributed to the Council at its next meeting.

The Housing Committee will meet the **first Wednesday of every month, 3:00-5:00 at 25 Van Ness Ave.** *TC* explained that the Committee is trying to address the question of community input as it pertains to housing. To begin that process, at its April 1st meeting the Committee will examine community input documents that have been compiled over the last several months. It is also beginning to examine the five-year housing plan, which requires revision. Also on April 1st, the AIDS Office and Redevelopment Agency will be presenting information compiled from focus groups conducted by SFAF. It has not yet been decided whether another community forum will be held or if a different method of gathering input will be implemented. This decision will be addressed after existing input is examined.

TC recalled that during the 1997 prioritization process the Council's progress on some decisions was delayed due to confusion around the CARE-HOPWA relationship. In May the Housing Committee will examine that relationship and the bodies' respective purviews to ensure that it is clear before the next prioritization process is begun.

TC noted that the prioritization process conducted this year may be structured differently than in the past, but the Housing Committee's current work plan is based on a prioritization process which ends in August.

In June the Committee will draft recommendations to the Council concerning the housing service category, which will be presented to the Council for review, discussion and suggestions. This list will be finalized by the Council in July, and final housing recommendations forwarded in August.

In September the Housing Committee plans to examine an assessment of the currently funded shallow rent subsidy programs, conduct a comparison of their models and possibly suggest changes.

JR recalled that the Housing Committee did not report its next meeting date at the last Council meeting, and asked how the Committee's March meeting was scheduled and how its members were notified. She added that she was not notified of that meeting. *TC* replied that this Committee has had ongoing trouble in scheduling and reporting meetings. The March meeting was scheduled by *TC*, *LT* and other members of the Committee. *LT* noted that *JR*, as a member of that group, should have been called. *TC* apologized for the Committee's lack of organization, and reiterated that it will now meet the first Wednesday of each month, 3:00-5:00 at 25 Van Ness Ave. He noted that there has been a general problem with Council- and Committee-related communication to members, due to a disorganized mailing system. *JR* expressed concern regarding the way in which the Housing Committee's standing meeting time was set, and suggested that the Housing Committee schedule be discussed at its next meeting. She noted that she is unable to attend the April 1 meeting. *TC* said that it can be rescheduled.

DJ reminded Council members that each Committee should notify the AIDS Office of its next meeting so that it can be listed on the schedule that is mailed with the Council meeting agenda. She added that the co-chairs are still discussing the problem of late and lost pre-meeting mailings with AIDS Office staff.

Consumer Representatives—HOPWA and CARE

TC explained that the Housing Committee is proposing the inclusion of consumer representatives, including residents of the facilities funded, to the CARE Housing Committee and HOPWA Loan Committee. He noted that this proposal has been presented to the Loan Committee and will be discussed at its next meeting, on March 20. At this time the Housing Committee is requesting the Council's endorsement of the proposal.

KW asked if consumer representation is to take the form of membership or presentations. *TC* said that the mechanism of representation is not included in this proposal. The Council is only being asked to endorse the concept of consumer representation. The nature of that representation will be discussed within the two bodies involved. *KW* noted that community representation to other Committees has never been voted on by the Council, and asked why it should be in this case. *TC* replied that at least Council support for the proposal as it relates to the HOPWA Loan Committee should be formalized by a vote. *LT* noted that Loan Committee members are Mayor-appointed, so consumer representatives would have to be appointed as well.

NN suggested that the issue of how consumer representation be provided to the Loan Committee should be discussed by that body, rather than the CARE Council. He noted that the HOPWA Loan Committee is actually the HOPWA Subcommittee to the Mayor's Loan Committee, which is advised by many other subcommittees as well. Appointment of consumer representatives to the HOPWA Subcommittee and not the others may be problematic. *NN* said that the CARE Council can suggest that increased consumer representation be sought regarding HOPWA, but should allow the Mayor and Redevelopment Agency to determine a mechanism. He noted that the HOPWA-CHIPS Advisory Committee has significant consumer representation from HOPWA-funded programs. In closing, *NN* expressed support for a proposal to recommend to the Redevelopment Agency that it seek ways to increase

consumer and PWA participation, but not for a proposal to request that consumers be added to the HOPWA Loan Committee.

TC clarified that the proposal does not address a mechanism for increased consumer representation, but simply the request that it be sought in some way. *TC* motioned for the Council to endorse increased consumer representation on the CARE Housing Committee and HOPWA Loan Committee.

JR noted that consumers are welcome to attend and participate in Housing Committee meetings, and asked what else the Committee could do to increase their inclusion. *TC* replied that he would like the Committee to do whatever it feels is necessary to increase community representation. He added that although community participation is welcomed at those meetings, it has not been evident in the group's process. *JR* expressed her understanding that one of the PWA Caucus' roles is to insure significant community input into the Council's and Committees' processes. Because the Council has already empowered the Caucus to carry out that role, it should not have to vote again on the importance of seeking consumer representation and participation.

LT explained that *TC* expressed to the Housing Committee his concern regarding consumer representation on the HOPWA Loan Committee. The Housing Committee, in discussing this concern, decided that if it is to ask another body to increase public participation, it should hold itself to the same standard, which is why the Committee was included in this proposal.

KW suggested that the language of the motion be changed from "representation" to "participation" in order to circumvent confusion around the type of representation being suggested.

MC clarified that the responsibility of soliciting community input was given to the entire Council and all its Committees when the Community Input Committee was dissolved in January. It is therefore not the responsibility of the PWA Caucus to seek input, although it did agree to oversee and coordinate that process as it is carried out in the other Committees.

TS asked what the HOPWA Loan Committee is and who sits on it. *JR* explained that the Loan Committee is a review panel that assesses HOPWA funding proposals being considered by the Redevelopment Agency. The CARE Council has historically appointed two representatives to the Loan Committee, but communication between the bodies has not been adequate, causing confusion about how the two funding streams are related. This lack of communication is currently being addressed. *NN* added that the HOPWA Loan Committee is part of the Redevelopment Agency's internal process. As part of the Redevelopment Agency's contract development process, it has a multi-agency task force, which was established through the Mayor's Office of Housing. This task force is responsible for examining the public funding directed toward public housing projects. The Loan Committee includes several subcommittees, which address specific projects according to their funding source. Thus, proposals involving HOPWA funding or the delivery of HIV-related services are examined by the HOPWA Loan Committee, which includes two CARE Council representatives. Those involving other services, such as mental health, are not reviewed by that body. Decisions made by the HOPWA Loan Committee are actually recommendations to the Redevelopment Agency, made prior to its decision whether to sign a contract.

Norma Thompson, of the Redevelopment Agency, clarified that proposals for funding of non-profit HIV service and housing providers are not addressed by the Redevelopment Agency before review and approval by the HOPWA Loan Committee.

TC recalled that in the 1997 prioritization process the CARE Council and Redevelopment Agency reached the agreement regarding the HOPWA rollover that HOPWA would fund staff for the residential sites involved. Contract revisions outlining this change in funding structure are now being reviewed by the Loan Committee. *TC* withdrew the proposal and said that he will raise the issue of consumer representation with the Housing Committee and HOPWA Loan Committee and report their recommendations back to the Council for further discussion.

WC noted that housing issues addressed by the Council are very technical and complex, and encouraged new members who are interested in understanding them to attend Housing Committee meetings.

IX. **Evaluation and Assessment Committee:**

Russ Zellers, of the AIDS Office, introduced himself and explained that he will give the Evaluation and Assessment Committee report at this meeting, in *AR*'s absence. He distributed the modified Reductions Protocol, developed by that Committee. The Reductions Protocol is the set of guidelines used by the AIDS Office to reduce funding to specific contracts. *RZ* recalled that in the last prioritization process the Council directed reductions of funding to food, case management and mental health services. In order to make those reductions specific criteria must be used to assess the performance of each contractor in question. The old protocol has been simplified so contractors can be notified of their reductions quickly, and because the AIDS Office is currently understaffed. This simplification has attempted to focus on whether providers are serving the populations of severe need, as identified by the Council last year.

RZ reviewed the modified Reductions Protocol. The first criterion is still Contractual Goals, from which "accomplishment of process and outcome objectives" and "current invoices" have been removed. The second

criterion to be applied—Severe Need—has been modified by removal of program uniqueness measures. The Evaluation and Assessment Committee developed a questionnaire to be used in determining the level of need met by each provider (which *RZ* distributed). The third criterion is Client Satisfaction, which will be assessed using the three measures outlined in the protocol. The measure of compliance with AIDS Office guidelines for grievance procedures was removed from this section. Compliance with those guidelines will instead be part of an ongoing monitoring process. The final criterion is Cost Effectiveness, which has been modified by including only one year, rather than the previous two.

RZ distributed the document which outlines the 1997 prioritization directives and questionnaires to be used for the reductions of food, case management and mental health services. He directed Council members to compare the directives in each category to the corresponding questionnaire, where it should be apparent that the directives are addressed. He noted that the mental health service questionnaire was developed by a mental health provider work group that was organized by the Evaluation and Assessment Committee for that purpose. *AR* and *RZ* attended that group as well. The questionnaire is designed not only to inform reductions, but also to ascertain what populations are served by long-term psychotherapy, which the Council found to be crucial and lacking information in its last prioritization process.

KW asked if later start-up dates of some programs will be taken into account when assessing accomplishment of contractual goals. *RZ* replied that they will.

TS asked what aspects of the Contractual Goals criterion were removed in the modification of the Reductions Protocol. *RZ* said that invoicing and "accomplishment of process and outcome objectives" have been omitted.

LT thanked the Evaluation and Assessment Committee for its work, noting that input from different Committees regarding the Reductions Protocol has at times been conflicting. She moved to approve the modified Reductions Protocol. The motion was seconded.

MC asked why compliance with AIDS Office grievance procedure guidelines was removed from the protocol. *RZ* replied that that information is not currently available, and will be collected through a monitoring process instead, in order to facilitate reductions. *Billy Pick* added that creation of an HIV Client Advocacy office, which the PWA Caucus is addressing, may change the grievance process.

WC thanked *RZ* for his work, and asked *Jim Illig*, of the Contractors Association and Project Open Hand, for his opinion of the new Reductions Protocol and questionnaires. *JI* explained that the Contractors Association participated in development of the protocol. The association's primary concern was that the AIDS Office use information only from the contract year that ended February 28 of 1998 to form reductions, which it has decided to do. *JI* noted that completing the questionnaires will provide contractors with extra work, but they are generally satisfied with the changes made to the protocol.

NN noted that the documents presented by *RZ* reflect a substantial amount of work by AIDS Office staff, and their implementation will require even more effort on the part of program managers. He noted that the Council usually requires a significant amount of information from the AIDS Office to inform its prioritization process, and suggested that the Council begin to consider what information it will need so that AIDS Office staff are not asked to collect it all at one time, while simultaneously implementing reductions. *WC* observed that the AIDS Office is farther along in the process this year than last, which will positively effect the Council's prioritization process. *NN* replied that last year's prioritization process was conducted four months earlier than usual, which is why the office was behind. *Billy Pick* reminded the Council that the AIDS Office is currently conducting an RFP process, which it should consider when requesting information.

MD called a question.

JI recalled that the Council prioritized categories to be augmented with additional funding, which were to be incorporated into the integrated service system section of the RFP. However, according to information given at the Bidders Conference, additional funding was not allocated to those categories. *JI* asked if it will be used to offset reductions in funding to mental health, case management and food. *TC* replied that it will not, and asked that *JI*'s question be addressed after the vote because it does not directly relate to the motion on the table.

The motion restated: **to approve the Reductions Protocol, as modified by the Evaluation and Assessment Committee.** A roll call vote was held and the motion passed unanimously, two abstentions **[2]**.

TC asked AIDS Office staff to report the outcome of this protocol's implementation to the Evaluation and Assessment Committee. The staff present agreed. In answer to *JI*'s question regarding additional funding, *RZ* explained that additional funding for the mental health category has been put out to bid in psych consult. Case management funding is also out to bid. He was unsure what has been done with additional funding for the food category. *TC* requested that a more detailed report on additional funding be presented at the next Evaluation and Assessment Committee meeting, which will be **Monday April 5, 5:00-7:00 at 25 Van Ness Ave.**

X. **Planning Committee:**

LT distributed and reviewed the Planning Committee's 1998 work plan. She explained that at its last meeting the Committee reviewed the DPH's proposed budget, and hopes to organize an AIDS Office presentation of that budget at the next Council meeting. During the coming months the Committee will focus on supporting the Council's prioritization process, particularly by conducting an evaluation of other funding streams and aiding the DPH in its efforts to better integrate services across funding streams.

At its April 2 meeting the Planning Committee will discuss funding for substance abuse treatment services and the prioritization of the Treatment On Demand Council. In May the Committee will discuss mental health funding, followed by primary health care, MediCal and the city's plans for Universal Health Coverage in June. Throughout this time the Committee will try to coordinate its work with Evaluation and Assessment.

The next Planning Committee meeting will be **March 25, 10:30-noon at 25 Van Ness Ave.** to consolidate its work plan. *LT* encouraged Council members to attend Planning Committee meetings, and noted that throughout the year the group will be developing and organizing presentations to the Council.

XI. Steering Committee:

DJ recalled that at its last meeting the Council approved a general outline of Planning Council Support fund allocations. Since then the Steering Committee and co-chairs have been developing a more detailed plan, including who they would like to implement the functions listed under Planning Council Support. The Committee has met with members of the Support Center to discuss the services which that group can offer. Another idea that has been raised regarding Planning Council Support is the creation of a transition plan in which someone would serve as main administrative coordinator for the Council. She noted that there is currently a lack of coordination due to AIDS Office under-staffing, which needs to be addressed. The specifics of this plan will be discussed at the next Steering Committee meeting, which will be **Monday, April 13 from 5:00 to 7:30 at 25 Van Ness Ave.** Those interested are welcome to attend. Proposal developed at that meeting will be presented at the subsequent Council meeting.

Mayor's HIV/AIDS Summit Recommendations

DJ explained that the co-chairs have met with *Dick Pabich*, who is charged with organizing the follow-up to the Mayor's HIV/AIDS Summit, to discuss the Summit recommendation that specifically involve the CARE Council. A formal letter of response to these recommendations will be drafted and presented to the Council for approval at its next meeting. *DJ* noted that some of the recommendations are already being implemented, and others fall outside the purview of the Council, as understood by the co-chairs. She asked those interested in discussing the HIV/AIDS Summit recommendations to contact her. *SL*, *MD*, *TC* and *MS* expressed interest.

LiO asked if the recommendations to which *DJ* is referring are from the document published after the Summit and the Summit itself. *DJ* responded that they are. *Dick Pabich* noted that all the recommendations presented at the Summit will be included in the final addition of that document. *DJ* clarified that the letter which comes from the CARE Council will respond only to those recommendations which specifically address the Council.

HRSA

TC distributed a letter that he and the other Council co-chairs recently received from HRSA. He noted that shortly after receipt of this letter he, *LT* and *NN* participated in a conference call with HRSA representatives, of which *LT* has drafted a written summary, which will be attached to the minutes from this meeting.

LT explained that the Health and Resources Services Administration (HRSA) is the Federal agency that administers CARE funding. Conference calls are regularly held between HRSA and selected cities receiving Title I funding, and in the past San Francisco has been one of the participating cities. However, the list of participants will change soon and San Francisco removed, meaning that it can listen to the calls but not participate. In the last conference call it was announced that several HRSA staff members are leaving the agency, including *Anita Eikler*, who has been very active in the administration of Title I funding. Also, HRSA is changing its method of administering funds. On eof the main changes is that the grant period will be extended to three years in order to reduce the effort required of the grantee. The distribution of funds will still be determined by a formula, which is primarily based on the number of AIDS cases in each EMA. The supplemental portion is still based on applications, but the applications will be less comprehensive. Another change will be the addition of Norfolk Virginia and Las Vegas Nevada as Title I eligible cities in the next year. Also, there will be no national technical assistance conference in the coming year.

WC asked what is the potential impact of these changes on the Council's prioritization process. *LT* replied that there will be no impact on the Council's process because it still has to prioritize the use of funding, although the grantee's process of insuring that funding will be modified. *NN* recalled that prior to 1997 the grantee was required to submit two funding applications to HRSA; one in October, and another (for supplemental funding) in December. In 1997 those applications were combined, which reduced the amount of work but resulted in scheduling problems. This year there will also be one combined application, but the questions that the grantee must answer in that application will probably be unknown until close to the date when it is due.

TC said that HRSA it trying to make the application process less labor intensive. The application guidance has not yet been issued, as *NN* said, but a draft will be distributed eventually and the Council will have the opportunity to

comment on its contents. He added that HRSA will follow up on the progress reports for the Council and grantee in the areas of grievance procedure implementation, assessment of the grantee and open nomination processes for new members. The Council needs to be cognizant of the scrutiny which it will receive in those areas. *TC* expressed the opinion that this Council is doing fairly well regarding grievance procedure implementation and the open nomination process, but not regarding its responsibility to assess the grantee. He concluded that guidance from HRSA will be reported to the Council as it is received.

Dick Pabich asked if the amount of funding to be received will still be a main concern with the new funding distribution method. *TC* replied that that will always be a concern. *LT* added that there are two main determinants of the funding amount: the amount of Title 1 dollars, which depends on the Federal appropriations process, and the competitiveness of applications for supplemental funding. This year there will be discussions of changing the formula used to determine funding distribution across the country, which could have a large negative effect on San Francisco. The Council will be updated on those discussions as they occur. *NN* noted that the increasing number of Title I eligible EMAs can also affect funding. *Billy Pick* said that another concern is the switch from internal to external reviewers for funding applications

XII. **New Business**

KW suggested that during the prioritization process it would be more efficient to hold full Council meetings on alternate Mondays, rather than the third and fourth Monday of each month. *TC* asked that that issue be referred to the next Steering Committee meeting, and suggested that *KW* either attend that meeting or ask a committee chair to raise the issue.

XIII. **Adjournment**: 7:35 p.m.

ATTENDANCE AND VOTING RECORD

P=present; A=absent; E=excused; L=leave of absence; Y=yes; N=no; B=abstain; R=proxy

	1	2		1	2
James Abrams	A		Diane Jones	P	Y
Kirsten Balano	A		Susan Karp	P	Y
Marianna Balquiedra	L		Tony Leone	P	Y
Troix Bettancourt	A		Steve Lew	A	
Jeff Byers	A		Norm Nickens	P	Y
Virginia Cafaro	P	Y	Lisa O'Connor	P	Y
Tom Calvanese	P	Y	Loras Ojeda	P	Y
William Carter	P	Y	Ron Reynolds	A	
Bart Casimir	P	Y	Alissa Riker	A	
Veronika Cauley	A		Nilda Rodriguez	P	Y
Fernendo Chavez	P	B	Joy Rucker	P	Y
Michael Chesek	P	Y	Barry Savage	P	Y
John Conley	P	Y	Matthew Sharp	P	Y
Mark Dunlop	P	Y	Thomas Sinclair	P	Y
Miriam Farooq	P	Y	Laura Thomas	P	N
Gene Gowdey	A		Brett VanBenschoten	A	
John Gressman	A		Kelly Wallace	P	Y
Danny Joe	A		Mary Jane Wood	P	Y

The Council meets on the first and third Monday of each month, at the time and place noted above. All are welcome and have the opportunity to comment on agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff at 554-9136. To request an excused absence (Council members only), contact Emily Coles at 777-3229. *Minutes of meetings are tentative until formally approved by the Council.*

Mayor's HIV Health Services Planning Council

March 23, 1998

SF Department of Public Health, AIDS Office, 25 Van Ness Avenue, Suite 330

AGENDA:

I.	Call to Order	4:30 PM
II.	Roll Call	4:35
III.	Review and Approval of Minutes	4:40
IV.	General Announcements	4:45
V.	Public Comment	4:50
VI.	Co-Chairs Report	5:00
VII.	Presentation and Discussion of FY 98-99 DPH Budget	5:15
	BREAK	5:45
VIII.	Discussion and Approval of Response to Mayor's HIV Summit Report (VOTE)	6:00
IX.	Steering Committee Report - Proposed Council Support Transition Plan (VOTE)	6:30
X.	New Business	6:50
XI.	Adjournment	7:00

Future Meetings: *All Meetings will be held at the AIDS office, 25 Van Ness Avenue*

March 25	Planning Committee	10:30 - 12:30
April 1	PWA Caucus	5:00 - 7:00
April 2	Planning Committee	2:00 - 4:00
April 6	Evaluation Committee	5:00 - 7:00
April 8	Housing Committee	11:00 - 1:00
April 13	Steering Committee	5:00 - 7:00
April 20	Council Meeting	4:30 - 7:30
April 27	Council Meeting	4:30 - 7:30

The site is fully accessible, and assistive hearing devices and signing are provided upon adequate notice. Minutes of the meetings and all information distributed to Council Members are available for inspection and copying. For further information contact Council staff at 554-9136. The closest BART Station is Civic Center. Accessible MUNI lines serving this location are: #71 Haight/ Noriega, #9 San Bruno, F Line to Market and Van Ness, and Metro Van Ness Station. For more information about MUNI accessible services, call 923-6142. Minutes of meetings are tentative until formally approved by the Council.

PROPOSED ORIENTATION PLAN

Membership Committee, HIV Health Services Planning Council

March 16, 1998

I. Description of CARE Act and Discussion of Roles and Responsibilities of Council members. (Tom Calvanese)
II. Structure and organization of Council including attendance, leaves of absence, conflict of interest, basic Robert's rules, voting and confidentiality. (Michael Chesek)
III. Description of Subcommittees. (Susan Karp to organize - Committee Chairs will describe and discuss work of each committee.)
IV. Overview of Prioritization Process. This section will include a description of service categories, examples of agencies, and basic information regarding the organization of services in EMA. (Diane Jones)
V. Discussion of AIDS Office and CARE Council distinctiveness of roles. (Will Carter and Michelle Dixon)
VI. Description of Mentoring Program. (Tony Leone)
VII. Question and Answer Period.
VIII. Welcome Reception.

Additional points of information:

- We expect that the orientation will take place in a single, three-hour meeting. After reviewing the information they have been presented, new members will then have the opportunity to request additional trainings or follow-up as needed.
- The orientation will be conducted by an outside facilitator who will work closely with the Membership Committee. This will be part of the Planning Council Support budget, and information regarding who exactly will be facilitating will be presented as soon as the details are known.
- Since new members have already been appointed, our goal is to hold the first orientation by mid-April. This does not leave much time for preparation, so participation and effort on the part of *all* Council members is requested to bring this project together successfully and on schedule.
- In addition to the orientation, within two weeks of appointment, all new members will receive an information package including the following documents:

  1) Green, Ryan White CARE Act, Title I Manual
  2) Red, CARE Act Training Guide
  3) *Current and Updated* By-laws
  4) Five Year Plan
  5) FY 1998 Supplemental Grant Application
  6) Copies of Meeting Minutes from the *last six months*
  7) *Current and Updated* Contact List

NOTES FROM 3/10/98 HRSA CONFERENCE CALL

San Francisco representatives on call: Laura Thomas, Tom Calvanese, Norm Nickens.

1. Anita Eichler is leaving HRSA and moving to SAMHSA at the end of the month. She expressed her appreciation for having had the opportunity to work with us, and hoped she would continue to in her new job.

2. Joe O'Neill presented information on the HRSA proposal for a three-year grant period, with internal review of proposals. All grantees will be getting letters extending the current grant period (usually a year) for two more years. HRSA will continue the single application, single award process they started this year. The rationale behind the change is that HRSA is trying to be responsive to EMA requests to streamline the application process, and reduce the huge amount of effort which has to go into the application every year. The Formula portion of the award will continue to be set by the Formula, and the Supplemental portion will be determined by a number of factors: fiscal and programmatic performance; timely submission of responses to any conditions of award; and responsiveness to the application guidance. Instead of the usual external review panels, the application will be reviewed internally, by HRSA staff. HRSA is currently developing the draft guidance, which they will circulate as soon as it is done for review and comment.

3. Sue Geisler from Denver asked what would be dropped from the old guidance. Joe did not have specific answers, but said it would be in the draft.

4. Sheila McCarthy of HRSA gave an update on the new EMAs which will be on the next conference call: Dallas, Detroit, Kansas City, San Diego, Jacksonville, Hartford, Jersey City, Boston, San Juan, Sacramento, and Phoenix. San Francisco will no longer be an active participant on the calls, but can listen it.

5. HRSA outlined some things they are expecting to look at in the FY 98 Progress Reports: follow up on the implementation of the grievance procedures, grantee assessment mechanisms, and the open nominations processes.

6. Planning grants are going to Norfolk, VA, and Las Vegas, NV. They will be coming on as new EMA's next year.

7. There will be NO national technical assistance meeting this year.

8. There will be a technical assistance conference call on adherence on April 8th.

PLANNING COMMITTEE WORKPLAN 3/16/98

The Planning Committee will be pulling together information and presenting in to the Council to support the 1998 prioritization process. Our focus is on evaluating external funding streams, and on encouraging greater integration of CARE-funded services and priorities with other Department of Public Health planning and service provision processes. Over the next few months, we will be gathering information on relevant topics, and then presenting it to the full Council, in coordination with the Evaluation Committee where possible. Here is the agenda for our workplan. All Council members are encouraged to attend our meetings. We will be coordinating presentations to the Council on these topics, but there will be more time to ask questions and discuss the issues in the committee meetings.

April 2, 2-4 pm.	Planning Committee meeting on **substance abuse** with chairs of Substance Abuse Treatment on Demand Planning Council Chairs. Presentation at April Council meeting.
May 7, 3-5 pm.	**Mental Health** discussion. Presentation at May Council meeting.
June 4, 3-5 pm.	**Primary health care,** including Medi-Cal and universal health care planning. Presentation at June Council meeting.
July 2, 3-5 pm.	Progress report on **DPH integration.** Presentation at July Council meeting.

Committee meetings are held the first Thursday of each month, from 3-5 pm, unless otherwise stated, and at 25 Van Ness.

Laura Thomas
Planning Committee Chair
487-3046

Mayor's HIV Health Services Planning Council
Minutes of Meeting

March 23, 1998

I. **Roll Call [1]**

II. **Approval of the Agenda:** The agenda was approved unanimously.

III. **Approval of the Minutes:** Minutes of February 23 meeting approved, with 19 in favor, none opposed, and 4 abstentions [2].

IV. **General Announcements:**

A. Veronica announced that she had brought fliers for this year's AIDS Candlelight Memorial and encouraged Council members to attend.

B. John Conley reported that Catholic Charities, under contract in San Mateo County to operate Belmont House, determined last November that the facility would have to close on January 31. The San Mateo County AIDS Program then successfully petitioned the City of Belmont to direct $80,000 of low-income housing funds to allow Catholic Charities to continue operating Belmont House through the current fiscal year, which expires on June 30,1998.

However, because it has been determined that the AIDS Program is unable to fund the $570,000 yearly operating cost of Belmont House, a effort is being made to convince the San Mateo County Health Department to take over the facility after June 30.

In order for this transfer to take place, the AIDS Program may have to contribute some funding to Belmont House. In addition, the capacity of the facility may need to be increased by expanding its client base to include people with chronic illnesses other than those related to HIV. As a multi-use facility, Belmont House would qualify for additional funding from other areas of the Health Department which would enable it to continue operating.

John reiterated that negotiations are still ongoing and that no final decision has been made. Although options for the five current residents of Belmont House are currently being explored, San Mateo County Health Director Margaret Taylor has publicly committed herself to maintaining the facility for the county. And in light of the lack of response to an RFP sent out for Belmont House's services, it seems San Mateo County will have to take over the facility itself if it wants it to continue operating after June 30.

C. Lisa announced that the AIDS Update Conference starts tomorrow (March 24), and continues through Friday. She informed Council members that admission is free for people with AIDS, and asked that they pass this information on to their clients.

D. Norm circulated the current membership list and explained that it is in the process of being updated. He asked members to review it and make any revisions to their personal information before the list is finalized and mailed to the Council.

Norm also reported that a Statement of Economic Interest was mailed out to Council members. He asked that they be submitted to the AIDS Office as soon as possible as they must be bulk-mailed to Sacramento by April 1. Any members with questions regarding the form can contact Eric Sorensen at the AIDS Office, 554-9000.

Finally, Norm passed out a March 16 memorandum from Dr. Katz responding to the Council's request for an update with regard to home health contracts. He informed the Council that Monique Zmuda, Chief Financial Officer at the DPH would be arriving shortly to give a presentation on the department's proposed FY 98-99 budget.

Diane asked the Council to examine Dr. Katz's letter and then pose any questions or comments. Tom asked for clarification of the last sentence in the second paragraph which refers to "reductions in the total contract amount" authorized by the CARE Council. Norm explained that some contracts were scheduled for a reduction as a result of the last prioritization process, and that the new contracts will be issued in a lesser amount. Tom requested that the Council be informed as to which contracts have been reduced and by what amounts. Norm agreed to provide the information at the next Steering Committee meeting.

E. Michael stated that the next membership meeting was not included in the meeting announcements. The next Membership Committee meeting will be held on Friday, April 3, at 9:00 a.m. at the AIDS Office, Room 330. He also

suggested that a list of Committee meetings and the rooms in which they are held be available at the front desk at the AIDS Office. Co-Chairs were advised to contact Eric Sorensen to reserve meeting rooms.

V. **Public Comment**

Michael Petrelis told the Council that he has obtained minutes of the HOPWA/CHIPS Advisory Committee meetings, and said he was shocked at the way housing issues are currently being handled. He explained that although there seems to be money available, the agencies involved don't seem to willing to hire people or utilize volunteers to perform the intake required.

Michael stated that, according to the Advisory Committee's agenda from a couple of weeks ago, there was to be a vote regarding housing issues, but the minutes from that meeting have not arrived yet. However, he did have minutes from the last 18 months of Advisory Committee meetings, and offered copies to Council members working on housing issues who are interested in pursuing the issue.

He then asked that the Council address the following issues with regard to housing:

1) Observing that notification of meeting dates would be helpful to clients, Michael asked why the HOPWA-CHIPS Advisory Committee meetings are not publicized, especially through the Council.
2) He also expressed the opinion that the current client grievance procedure is misleading and ineffective. He noted that some agencies are not abiding by AIDS Office guidelines which specify that a client grievance procedure be in place and that information regarding this procedure be prominently posted at the facility.

In addition, he expressed concern with the language that exists in both CARE and HPPC contracts with regard to client grievance procedures. He said that both contracts not only maintain that grievances can be effectively handled at the agency level, but state that should the situation not be resolved to the clients satisfaction, (s)he can then file a complaint with the Human Rights Commission. According to Michael, the Human Rights Commission then tells clients that there is nothing they can do to help them.

Tom responded that the Housing Committee would be discussing the inclusion of resident representatives on both the Housing and the HOPWA Loan Committees at their next meeting. He suggested that Michael voice his opinion with regard to the HOPWA/CHIPS Advisory Committee there, as the Housing Committee would be the most appropriate body to deal with the issue. The next Housing Committee meeting will be held on April 8, from 11AM-1PM at the AIDS Office, Room 330 B.

With regard to the current client grievance procedure, Will asked Michael to put together a short statement detailing his concerns, which he said will be forwarded to either the Steering or the Assessment Committee for investigation. Michelle stated that the Office of Contract Management would need to correct the language in the contracts to designate the appropriate department at the Human Rights Commission for handling grievances. She offered to refer the matter to the department and report back. Will also requested that Michelle and a representative from the AIDS Office attend the next Steering Committee meeting to further deal with the issue.

VI. **Future Locations for CARE Council Meetings**

Diane announced that the AIDS Foundation Conference Room, where meetings were previously held, would be available for most, but not all of the dates that the Council plans to be meeting in the future. She asked the Council whether they preferred to continue meeting at 25 Van Ness, meet at the AIDS Foundation whenever possible, or seek an alternative location at which to meet . She also related that the War Memorial provides meeting space for public agencies, but did not know whether the rooms would be available in the evenings. By a show of hands, the Council elected to attempt to find an alternative space.

Matthew inquired as to how Council meetings are presently announced. Eric replied that the agenda is included in the mailings that go out to Council members, as well as posted at the library and listed in the Bay Area Reporter. Matt suggested that because the Council does not always meet at the same location, it is especially important that the public be notified where the next meeting will be held. Diane agreed, and noted that a consistent meeting place would be desirable for the Council as well. She said she would find out the specifics of meeting at the War Memorial and report back at the next meeting, which, for now, will be held at 25 Van Ness.

VII. Approval of Response to Mayor's HIV Summit Report

The Council examined a draft of the Council's response to the Mayor's January 27 summit on AIDS and HIV. Diane noted that the preliminary report issued prior to the summit obviously did not include what actually transpired at the event. She explained that a final report, which will include what occurred on the day of the summit as well as various other attachments and addenda, will be forthcoming.

She said that Co-Chairs met with Dick Pabich to discuss items to be included in the Council's addendum, and it was determined that a general response to the summit, rather than to specific issues addressed in Committee reports would be most appropriate. After reviewing the draft, the Council had the following comments:

- Matt asked for clarification of item 1) on the list of recommendations, which speaks to the Council looking forward to working with the HPPC and the AIDS Office "to explore combining funding to allow for comprehensive services."

Diane explained that this issue came about as a result of some of the discussions after the last prioritization. She recalled many providers expressing frustration because the flow of funding streams contradicts their ability to effectively provide integrated services.

She cited as one clear example the implementation of the Tenderloin Care Grant last year, which represented an innovative effort to provide integrated services. When people on the street were asked what services they most needed, they requested HIV testing, a service neither anticipated nor provided for in the funding because it is considered a prevention strategy rather than a direct service. As a result, the request was difficult for contractors to respond to because funding streams did not provide money strictly for prevention.

Steve noted that the Prevention Committee of the Mayor's Summit had recommended that primary prevention messages be incorporated into the health delivery system. He clarified that this was not a suggestion that prevention funds be directed to health care, but rather that the intentions behind the funding be used to better guide contracting in the future.

In terms of Matt's concern, he suggested that the letter be reworded to state that the Council would look forward to working with the HPPC and the AIDS Office "to better coordinate and maximize funding." He noted that this terminology still highlights the main goal, which is to provide clients with comprehensive services.

Tom proposed that one way to better coordinate CARE-Prevention dollars would be to look at the possibility of issuing a joint RFP. He noted that this method would incorporate funding streams more effectively than combining funds.

- With regard to item 2), Lisa said that she would like to see women added to the categories of people who have historically not benefited from advanced treatments and HIV services. She expressed concern that issues with regard to HIV in the African-American community were addressed at the summit, but that there was no mention of the impact of HIV on women. In particular, she noted that with regard to prevention, it is African-American women who are the fastest rising group in terms of new cases of HIV.

Will said that the language in the response reflected that used in grant applications submitted by the Council after last year's prioritization. He said that with regard to communities found to have been underserved, it was found that, in terms of the level of service to women with HIV, the Council was doing a pretty good job. What the evidence did show, however, was that there was a lack of services accessible to youth and the African-American community.

- Mark suggested that the line in item 3) which reads, "We will pursue continuing to educate the Council regarding housing issues" sounds as though the Council is trying to educate themselves. He said that the item would be clearer if reworded to state that the Council is committed to working with homeless and housing representatives from the Mayor's Office to more effectively integrate the housing service system.

- Matt noted that both the planning of and preliminary report on the summit included recommendations to the Council on action to be taken and service categories to be funded. He suggested that the Council's response include a line addressing those recommendations.

Diane directed members to examine item 4) in the draft, which she said to a great extent addressed the Mayor's recommendations. She noted that many of the Mayor's directives involved an attempt to redirect the Council with regard to allowable use of funds and fell under the framework of the impact of new therapies on the changing demand for services.

She said that item 4 pertains to those issues by explaining the mechanism by which the Council considers the distribution of funding.

Dick suggested that the item could more specifically state how the Council's process addresses the Mayor's recommendations. To this end, the Council determined that item 4) be revised to more explicitly state that the directives that came out of the summit would be carefully considered within the current process of prioritization.

The Council then voted unanimously that Diane would incorporate the suggested changes in the Council's response and forward a revised letter to the Mayor's Office.

VIII. Presentation of proposed FY 98-99 DPH Budget

Norm introduced Monique Zmuda, the Chief Financial Officer at the Public Health Division of the Department of Public Health, the office which funds CARE and mental health state-funded activities.

Monique distributed copies of the Department of Public Health's proposed FY 98-99 budget, which was approved by the Health Commission on February 17. She explained that it will next be forwarded to the Mayor, where it will be acted upon by he and his staff, and then translated into a citywide budget document for transmission to the Board of Supervisors on June 1. Ultimately, the Board of Supervisors will hold hearings on, may amend, and will approve the final budget in the months of June and July.

Monique stated that all city and county departments were instructed by the Mayor to develop a cost-to-continue baseline budget necessary to maintain the current level of services. She stated that any service enhancements or increases in funding beyond that would need to be presented as a separate proposal. The proposed budget combines both the baseline budget and a prioritized list of above-base service enhancements.

She referred to section 1. Introduction on page 7.4, which provides a summarization of the DPH's budget for the current year as well as next year. She explained that a situation occurs in which a couple of sets of books are maintained at the DPH; that in certain instances, allocated funding can get included or counted more than once. This may happen, for example, if the Public Health Division allocates money to San Francisco General Hospital. The money is counted in the Public Health budget, as well as in the San Francisco General budget.

She explained that part of her job is to make the necessary adjustments so that each dollar that touches the DPH is counted only once. She explained that by counting every dollar only once, the current year budget comes out to $751.0 million. However, if dollars were calculated by each budget to which they have been allocated, the total would reach $1.2 billion--a sizable difference.

She explained that the Council's Ryan White Grant is embedded in the current year $751. million budget, and reiterated that for next year, the DPH has requested cost-to-continue funding as well as above-base enhancements. As stated in the introductory paragraph on pg. 7.4, this would increase funding significantly in 1998-99 (by $86.3 million, for a total of $837.2 million). She warned the Council, however, that there was no chance that the DPH would receive the total amount asked for. She explained that funding is requested for all areas where it is known that unmet needs exist, knowing that the Mayor and the Board will ultimately have to prioritize among city services according to the amount of funding available.

Monique then referred to the General Fund table shown at the bottom of pg. 7.4. She explained that the DPH gets a certain amount of money from the City General Fund, which does not have to be reported or billed to the state or federal government. Here again she explained that an increase of between $10 and $15 million could more likely be expected.

Monique then referred to the DPH 98-99 Revenue Budget shown in the chart on pg. 7.5. She stated that the DPH's budget comes from a variety of sources, with the vast majority of revenue coming from: the federal government for health services to Medi-cal recipients (32%); the City and County General Fund (24%); and the State of California in vehicle license and sales tax revenue (16%). In addition, a variety of grants and allocations are received for substance abuse and mental health, as well as a small amount from patient revenues.

Two operating departments currently comprise the DPH. The Public Health Division, where the AIDS Office sits in, includes community health services, community health and safety, as well as health prevention and promotion. The Community Health Network incorporates all patient care services within the department, including San Francisco General, Laguna Honda, all the primary care clinics, and forensics. (See *II. Organization*, pgs. 7.6-7.7.)

Monique explained that the original DPH baseline budget was significantly reduced by the Mayor's Office. The Mayor's budget staff reviewed and analyzed the submitted budget proposal, and eliminated $7 million from the original request. Requests for funding are prioritized and compromises negotiated before the Mayor makes his final decision regarding the budget to be transmitted to the Board of Supervisors in June.

The FY 98-99 baseline budget includes costs that have already been approved, or adjusted to meet the approval of the Mayor and Board of Supervisors. The annualized cost of the substance abuse treatment expansion program, and six supplemental appropriations fall into this category, as well as an $8.0 million increase in personnel expense associated with current labor agreements. For details, see *III. Baseline Budget*, pgs. 7.8-7.11.

Monique then referred to the *VI. New Initiatives* detailed on pages 7.19-7.32 of the proposal. In the area of A. Treatment on Demand, the DPH has requested and received increased funding to annualize ongoing substance abuse treatment programs in various stages of implementation. It also includes a new initiative to further increase treatment slots beyond the current capacity.

Monique then addressed the DPH's request for mental health treatment (see B. Single Standard of Care-Mental Health Services, pgs. 7.20-7.21). She explained that currently, Medi-Cal recipients have greater access to CMHS's services and to new, more costly atypical anti-psychotic medications than do indigent residents who do not qualify for Medi-Cal. This initiative proposes a single standard of care which would provide expanded accessibility to mental health services and new psychotropic medications to 4,600 indigent and uninsured San Francisco residents.

In the area of Prevention, DPH has proposed an initiative which consists of four components: an African-American Health Task Force; injury prevention (which she cited as the number one cause of death in the City; substance abuse prevention; and prevention programs targeted to children and youth. (See pgs. 7.21-7.22.)

The DPH and the Department of Human Services have developed a program to provide housing and health services to homeless people who utilize the City's shelters and health care system (see D. Housing Services, pg. 7.22). Under this initiative, the DPH proposes to rent 150 new units of subsidized housing for the homeless and those with mental health, substance abuse, and HIV-related illnesses. Another component of this plan would house an interdisciplinary team of case managers on site to provide ongoing medical and social services to residents.

With regard to infrastructure, the DPH has requested a $3.2 million cost of living increase to adjust various operating expenses to reflect market inflation, as well as additional funding for administrative and support functions for DPH services. In addition, the Department has developed a three year plan to update and enhance its MIS infrastructure, which will include maintenance of new patient care modules and development of a citywide public health database. (E. Infrastructure, pgs. 7.22-7.33.)

The F. Lost Grants initiative requests funding for two grants expiring on June 30, 1998. Replacement of funding provided by The Robert Wood Johnson Children's Mental Health Grant would allow the Primary Care Interface Project; the Foster Care Mental Health Program; and the Adolescent to Adult Transitional Program to continue operating. The DPH's Substance Abuse Target Cities Grant currently provides funding for the Drug Court Program. Replacement funding would allow this program to continue, as well as enable selected other components of the Target Cities program to continue operating.

Additionally, the DPH has requested funding for various service enhancement initiatives, including the Rodent Control Program; Community Health Epidemiology Tracking; Juvenile Action Plan Assessment Center Staffing; Care of Complex Medical/Psychiatric, Geropsychiatric and Neurobehavioral Patients; various Mental Health Service Enhancements to expand current levels of service; Primary Care Mental Health Service Expansion; Continuum of Dementia Care; the Adolescent Health Initiative; Maternal, Child and Adolescent Nutrition and Perinatal Consultation; and Communicable Disease Screening. (For details, see G. Service Enhancements, pgs. 7.25-7.29.)

H. Cost of Living Increases for Contractors Providing Patient Care Services, (pg. 7.29), request a 3% cost of living adjustment to medical services agencies contracted by the DPH. I Revenue Generating New Initiatives are described on pages 7.30 and 7.31. An initiative to pilot Universal Health Care is detailed on page 7.32, as well as two HIV/AIDS Service Expansion proposals, which seek funding for a job re-entry program and Preventional Adherence Service sites in the City.

Laura thanked Monique for her time, and stated that she had a comment with regard to the CARE grant allocation as described in the last paragraph of section B. Grant Revenues on page 7.15. Laura noted that, although the CARE Council was able to match services to the existing award as stated, this was accomplished by cutting services for which the Council knew funding was not available. She wanted to make it clear that the Council's ability to match services to funding does not mean that the reduction in funding had little effect, or that despite the cut, all services are being taken care of and/or all needs are being met.

Monique acknowledged that the DPH is very concerned that CARE funding has been displaced in areas such as case management and mental health. She stated that to the extent that money becomes available, an effort will be made to replace funding in high priority areas such as housing, substance abuse, mental health and primary care. She noted, however that future allocations in these areas may be targeted to populations with severe need, which would include, but not be limited to clients with HIV.

Will asked for clarification regarding section K. HIV/AIDS Service Expansion, on page 7.32. He wanted to know if the proposals described in this section, i.e. those that came out the summit, are the only explicit requests with regard to additional funding for HIV/AIDS services.

Monique replied that many services that would be utilized by people with HIV and AIDS have been provided for in other areas. She cited that housing services have been merged with health care (section D. Housing, pg. 7.22), that substance abuse treatment could be accessed through the Community Health Network (A. Treatment on Demand, pgs. 7.19-7.20), and that much of the increase in the request for pharmaceutical services is associated with the rise in cost of protease inhibitors. She did acknowledge that the only proposals which specifically target PLWH, are those which came out of the Mayor's Summit on AIDS.

Will also stated that another issue that concerns the Council each year during prioritization is the expectation that every year the CARE grant will be further cut. He reminded her that the Council is dealing with a dynamic epidemic, and expressed the concern that if consistent reductions are what can be expected, people with HIV will be cut out altogether at the end of the grant year.

Monique responded that unless the disease "goes away," there would be no way that the Mayor and the Board of Supervisors would allow people living with HIV to be cut out of the public health budget. She suggested that if the Council perceives that funding is insufficient, either as a result of the reductions or because of increased need, that they make that position clear to the Mayor and the Board of Supervisors. She also stated that, although the Mayor has a list of priorities to juggle, this has not been a budget cutting year and there may be a possibility for more funding if the need is made clear.

Tom said that his perception of the DPH report is that there was a response on the part of the DPH to decisions made during last year's prioritization. He expressed the opinion that the fact that the DPH and the Council operate on different funding cycles contributes to a lack of planning between the two organizations. Noting that the Council would soon be entering into prioritization for next year's CARE budget, he inquired as to how the effort could be coordinated to insure that the DPH is involved in the process.

Monique acknowledged that, as it stands, the Council's prioritization process has already been completed by the late fall when the DPH's process is just beginning. She suggested that as the Council enters into prioritization this year, it keep in mind the 2% reduction in funding reflected in the DPH's proposed 98-99 budget. The Counsel should then make the DPH aware of any unmet needs as a result of the cut before it begins its planning process in the Fall for the following year.

Diane clarified for the benefit of new members that, when the Council began its prioritization process in the Fall, Dr. Katz came to the retreat and informed members that any cuts that they make will not be replaced with general fund money.

Laura expressed agreement with Tom's suggestion that some effort at coordination should be set up between the Council and the DPH. She stated that one of the reasons she supported the DPH budget presentation is that she thought the Council should be aware of what direction the DPH is headed as the Council goes into prioritization. In addition, she offered to make the Council aware of the Mayor's proposed budget when that has been prepared.

Laura also explained that much of confusion comes from the fact that the Council prioritizes their services without knowing how much funding will be allocated. As a result, several contingencies have to be planned, including those that prepare for reductions that may be made. In turn, funding agencies then can look at these plans and assume that if the Council can

provide services for a certain amount, its needs have been met, when, in fact, the Council has had to prioritize because funding is uncertain.

She suggested that the Council start identifying contingencies for what they want to see as priorities for general funds if CARE money is not received to fund them. This would then be a piece that the DPH could take out of the Council's prioritization process and prioritize it within the DPH's general fund budget. Laura noted that what is happening right now is that the DPH is not perceiving services that the Council has had to cut out as priorities. In fact, unmet needs exist because the Council has only been funded to provide services for those whose needs are the most severe. This results in a situation where people who fit in with DPH's criteria for receiving services are going without care, because there are not sufficient CARE dollars available.

Will reiterated that decisions made during the prioritization process are extremely difficult. When the Council cut services, particularly in the areas of substance abuse and mental health, the intention was not to say that services in these areas are no longer necessary for PLWH. Rather, the intention was for funding to be increased for other sources that currently provide services in the areas that the Council can no longer fund.

Monique acknowledged that many of the services that had to be cut are very important, but stated that the DPH is not able to pick up all the services that the Counsel can no longer fund. She insisted that although the Department would do its best to preserve CARE-funded services, it cannot guarantee that it will be able to maintain HIV-targeted caseloads that the Counsel is unable to carry.

Diane stated that the issue of the complexity of funding cycles needs to be effectively addressed in order to plan for a future in which CARE money may not be available for PLWH. She noted that the most significant problem is still the fact that the Councils prioritization ends before the DPH begins to prepare its budget preparation for the same fiscal year. She stressed that a process needs to be effected to incorporate funding agencies into this year's prioritization. This way, the City's budget can be prepared to reallocate funding to pick up the services that CARE dollars can no longer carry. She suggested that the issue be addressed at the next planning meeting, which Monique agreed to attend.

IX. Vote on allocation for REGGIE

Veronika stated that the issue of continued funding for REGGIE had been discussed at a previous policy meeting, and that, in her opinion, funding should continue. She said that not only had clients expressed interest in the program, but that in the long run, she thinks REGGIE would be an effective way of tracking and providing a continued level of care.

Will reminded the Council that if any member had a conflict of interest with regard to REGGIE, the issue needed to made clear before they entered into any discussion on the matter.

Tony also expressed support for REGGIE, but related that there was a great deal of misunderstanding among many in the community who have been asked about participating in the system. He said much of the concern stemmed from a perceived invasion of privacy and a lack of control over personal information. He suggested that a informational campaign to assure people that their right to privacy will be protected in the system might be helpful.

Will stated his familiarity with the capabilities of REGGIE, but said that his reservations are based on the substantial amount of money that has already been spent with little to show for it. His concern was that the Council would consistently allow an allocation for REGGIE to go through each year based on promises that the system would bring future benefits. He stressed that his view is not that REGGIE should not be funded, but that CARE money should not be automatically allocated to the system without a critical assessment of its progress.

To this end, Will stated his intention to present a two part motion. The first component would recommend that the current allocation of $180,000 for REGGIE go through; the second that the system be removed from the base or automatic funding category and instead be assessed on a yearly basis in terms of what has been accomplished and what would be accomplished if funding is renewed.

A roll call vote was held to approve a current year allocation of $180,000 to the ongoing development and implementation of the client information system known as REGGIE. The motion passed with 17 in favor, 1 opposed, and 1 abstention [3].

Will then presented a second motion to remove REGGIE from the base-funded category, and that future allocations for the system be contingent on proposals presented by the REGGIE task force.

Joy inquired about the mechanism that would be used to evaluate REGGIE each year in order to determine its effectiveness and whether it continues to be considered a wise investment for the Counsel. In addition, she suggested that should the Counsel decide that future allocations for REGGIE be dependent on specific criteria, the REGGIE task force should be clear on the criteria used to evaluate their efforts as well.

Speaking against the motion, Gene suggested that rather than remove REGGIE from list of base funded categories, it be kept on the list and funded at zero until an evaluation of its effectiveness can be made.

Diane also spoke against the motion, noting that most providers are aware of the fact that there is no guarantee of continued funding for maintenance of any program. However, she did suggest that the message be transmitted with the allocation to the REGGIE task force this year. She also expressed agreement with Joy that it would be wise to establish the criteria to be used in evaluating programs in the future and that this criteria should be made clear to those seeking funding.

Will acknowledged the opinions expressed by both Gene and Diane, but maintained that, at this point, REGGIE has not proven its case. He recalled that funding for the system *had* started at zero and was now at a level of $180,000. Again he urged the Council to require the people from REGGIE to come to the Counsel and justify the money that they need before it is allocated again.

Steve noted that REGGIE administrators have stated goals in the past, such as the number of providers that will be online in the next year, and that those objectives can be used to measure the degree of progress that has been made with the system so far. He also noted that REGGIE represents the only effort the Council is making in the area of system wide development, and that, in fact, the project has been moved off of CARE and is presently being funded mainly from other sources. He said that simple outcomes should be created for REGGIE, and that as long as the Council remains clear on what is expected, he would support continued funding for the effort.

Tom suggested that at this point two efforts be made. 1) That a clear message be sent to administrators along with the money informing them of the Council's policy that there is no guarantee of funding for next year. 2) That in order to be considered for funding during next year's prioritization, administrators of REGGIE will be expected to present a proposal to the Evaluations Committee. Tom also reminded the Counsel that, when each year the Council is faced with having to cut direct services for people with AIDS, it is extremely difficult to justify spending so much money on a marginally successful data management project.

Will expressed disappointment with the Council's decision to fund REGGIE in the current year, and agreed with the suggestion that Evaluations should take up the matter with regard for future allocations for the system. However, he stated that he would have to excuse himself from participating in Evaluations Committee discussions that concern REGGIE.

Kirsten reminded the Council that during prioritization last year, a substantial effort was made to scrutinize service categories which received the larger allocations. She stated, For example, that much attention was paid to whether they addressed target populations, their goals and outcomes, etc. She suggested that this year equal scrutinization be applied to programs which receive a substantial but relatively smaller amount. This would apply to programs such as REGGIE that fall under the program support category.

Loras expressed disagreement with the idea of spending $180,000 on a project both limited in scope and in terms of directly benefiting PLWH. He also stated that he found it arrogant that any program would use the fact that the Council had already made a substantial investment as leverage for receiving continued funding.

Tom reminded members that, with the exception of the allocation of current year dollars to REGGIE, any decisions with regard to funding for next fiscal year must be made during prioritization. He noted that in previous years the prioritization process consisted to a great extent of making adjustments to the existing budget. This year, however, he said the Council will enter prioritization with a zero-based budget, i.e., no guaranteed funding for any program until the process has ended.

In terms of REGGIE, Tom said that in light of the current debate, the system will most surely be one that is examined very critically. He reiterated his former point that it is essential that the Council use this period before prioritization to define its priorities and expectations with regard to allocating funding, and that this policy be made clear to all involved.

Finally, the Council agreed to refer the pending question with regard to future funding for REGGIE to the Evaluations Committee, who will investigate the issue and report back to the Council.

X. **Council Support Transition Plan**

Diane distributed the document outlining the breakdown of funding in the various areas which provide Planning Council support. She explained that the Steering Committee is currently examining the categories to determine the best way to allocate the money for next year. This decision will consider the services provided by both existing and other contractors and to a great degree be based on the work load for next year. It will also take into account the support needed for this year's prioritization, especially in the areas of technical support and data and information collection and analysis.

In addition, she stated that one idea that had been discussed was the hiring of a project manager to coordinate support for the Council. This person would be considered part of the Council staff and report to the Council via the Steering Committee. She explained that much of the difficulty that the Council has faced in the past has been due to the lack of a point person to oversee the administration of support that the Planning Council needs.

A roll call vote was held to delegate to the Steering Committee the implementation of the Planning Council Support Work Plan, including the hiring of a project manager. The motion passed unanimously, no abstentions [4].

XI. **Adjournment:** 7:47 p.m.

The next CARE Council meeting will be held on Monday, April 20, from 4:30-7:30 p.m. at the AIDS Office, 3rd floor Conference Room.

ATTENDANCE AND VOTING RECORD

P=present; A=absent; E=excused; L=leave of absence; Y=yes; N=no; B=abstain; R=proxy

	1	2	3	4		1	2	3	4
James Abrams	A				Diane Jones	P	Y	Y	Y
Kirsten Balano	P	A	Y	Y	Susan Karp	A			
Marianna Balquiedra	L				Tony Leone	P	Y	Y	Y
Troix Bettancourt	A				Steve Lew	P	Y	Y	Y
Jeff Byers	A				Norm Nickens	P	Y	Y	Y
Virginia Cafaro	P	Y	Y	Y	Lisa O'Connor	P	Y	Y	Y
Tom Calvanese	P	A	Y	Y	Loras Ojeda	P	A	N	Y
William Carter	P	Y	Y	Y	Ron Reynolds	A			
Bart Casimir	P	Y			Alissa Riker	P	Y	Y	Y
Veronika Cauley	P	Y	Y	Y	Nilda Rodriguez	P	Y	Y	Y
Fernando Chavez	P	Y	Y	Y	Joy Rucker	P	Y	Y	Y
Michael Chesek	P	Y	Y	Y	Barry Savage	A			
John Conley	P	Y			Matthew Sharp	P	A	A	Y
Mark Dunlop	P	Y			Thomas Sinclair	A			
Miriam Farooq	A				Laura Thomas	P	Y	Y	Y
Gene Gowdey	P	Y	Y	Y	Brett VanBenschoten	A			
John Gressman	A				Kelly Wallace	P	Y		
Danny Joe	A				Mary Jane Wood	A			

MAYOR'S HIV HEALTH SERVICES PLANNING COUNCIL

April 20, 1998

SF Department of Public Health AIDS Office, 25 Van Ness Avenue, Suite 330

AGENDA

I.	Call to Order	4:30 PM
II.	Roll Call	
III.	Review and Approval of Agenda	
IV.	Review and Approval of Minutes of 2/23/98 & 3/16/98	
V.	General Announcements	
VI.	Public Comment	
VII.	Reports	
	A. Membership Committee Report 1. New Members (VOTE) 2. Bylaws Change (VOTE) 3. Leave of Absences (VOTE)	5:05
BREAK		6:00
	B. Steering Committee Report 1. Additional Funds (VOTE) (food, home health) 2. Planning Council Support 3. General Fund Priorities	6:15
VIII.	New Business	7:00
IX.	Adjournment	7:15

Up-coming Meetings:

April 27, 1998 -- Planning Council, AIDS Office, 25 Van Ness Ave., 3rd Floor Conf. Rm, 4:30 -- 7:30 PM
May 1, 1998 -- **Membership**, AIDS Office, 25 Van Ness Ave., Suite 330-B, 9:00 -- 11:00 AM
May 4, 1998 – **Evaluation and Assessment**, AIDS Office, 5th Floor Conference Room, 5:00 – 7:00 PM
May 6, 1998 – **Housing**, AIDS Office, 5th Floor Conference Room, 11:00 AM – 1:00 PM
May 6, 1998 – **PWA Caucus**, AIDS Office, Suite 330-A, 5:00 – 7:00 PM
May 7, 1998 – **Planning**, AIDS Office, Suite 330-B, 3:00 – 5:00 PM
May 11, 1998 – **Steering Committee**, AIDS Office, 5th Floor Conference Room, 5:00 – 7:00 PM
May 18, 1998 -- Planning Council, AIDS Office, 25 Van Ness Ave., 3rd Floor Conf. Rm, 4:30 -- 7:30 PM

San Francisco Department of Public Health, AIDS Office, 25 Van Ness:

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HIV HEALTH SERVICES PLANNING COUNCIL
Minutes of Meeting

April 20, 1998

DRAFT

I. **Call to Order:** 4:45

II. **Roll call [1]**

III. **Agenda Review and Approval**: the agenda was approved without changes.

IV. **Review and Approval of Minutes from February 23 and March 16**:

a. **2/23**: The minutes were approved without changes; *MB, JB, SL, NN, AR, KW* and abstaining.

b. **3/16**: the minutes were approved without changes; *MB, JB, AR* and *KW* abstaining.

V. **Announcements**:

a. *DJ* introduced *Leanne Monferdini*, President of the Health Commission, whose membership on the Council will be decided at this meeting. *LM* acknowledged the historical lack of regular Health Commission representation on the Council, and said that she will make every effort to rectify that problem.

b. *DJ* welcomed *Marianna Balquiedra* back to the Council after her leave of absence.

c. *MC* announced that he is acting as proxy for *Mark Dunlop* at that meeting.

d. *TS* noted that all Council members should have received invitations to the reopening of the Immune Enhancement Project, where he used to serve as executive director. He encouraged attendance of this event, and noted that this is the first time public funding has been used in California to support a traditional Chinese medical clinic. IEP serves low income PLWH and cancer patients. The reopening will be May 1, 5:00-7:00 at 3450 16th Street.

e. *LO* announced that Mobilization Against AIDS is planning the international AIDS satellite memorial mobilization, and he has nomination forms for awards to be given through that event. Recognition will be given to three PLWH and one organization that is responding to its local epidemic.

f. *MS* announced that the CMA has been planning to sponsor a mandatory names reporting bill through *John Peratta*. However, *Peratta* recently decided not to forward the bill, delaying the issue for at least another year. The HIV Surveillance Coalition is working on language for a new surveillance-related bill, which will not include mandatory names reporting.

g. *VC* reported that the REGGIE project is progressing as scheduled, and incorporated the Emergency Fund on April 17. The recent REGGIE policy meeting focused on emergency scenarios to insure only appropriate use of the data collected through this system.

h. *DJ* said that the co-chairs are still working with the AIDS Office staff to facilitate the mailing of Council information in a timely manner, and noted that pre-meeting packets for this meeting included updated membership lists. She circulated a list for members to double check and indicate any incorrect information.

i. *TC* explained that the letter enclosed in the pre-meeting packet was received from HRSA, and referred to at the last Council meeting.

VI. **Public Comment**:

a. *Jim Illig*, of the HIV Contractors Association and Project Open Hand, announced that the RFP applications of two HIV care service providers were initially rejected due to tardiness (by one minute). Both agencies asked the Contractors Association for assistance in convincing the AIDS Office to accept their applications. Not only did the AIDS Office decide to accept those applications, but has said that in the future there will be staff in the lobby of 25 Van Ness Ave. at noon of the RFP application deadline day to accept applications, and applications will be accepted until 5:00 p.m. of that day, with a point reduction for tardiness after noon.

b. *Dick Pabich*, HIV advisor to the Mayor, introduced his new assistant, *Bill Barnes*, who will attend CARE Council meetings with him, and in his place when necessary. *BB* is a member of the HIV Prevention Council, and newly hired by the Mayor's office.

VII. Membership Committee Report:

New Member Nominations

MC said that the Council currently has 35 members and 5 vacancies. The Membership Committee has submitted 3 nominations to the mayor, 2 of which are Health Commission and MediCal representatives. An agreement was reached with *Dick Pabich* that the Committee will submit two nominations for each vacancy in order to give the Mayor greater discretion in Council appointments. The Membership Committee has decided that in support of *Barry Savage* and his appeal for reappointment, his name will be kept on the list of nominees until he is reappointed. The next three names to be submitted to the mayor are *Chris Bohm*, *Dorothy Bartolomucchi* and *Johnnie Norway*, all of whom were previously submitted, and will continue to be until their appointment. Three new nominees, to be submitted with the previous three and *Barry Savage*, are *Donald Bliss*, *Steve Oxendine* and *Sam Saul*. *MC* explained that *Donald Bliss* is a gay, HIV+ mental health and substance abuse clinician and consumer of CARE services. He is currently program director for men's HIV mental health services at New Leaf. *Steve Oxendine* is a co-founder of the African American Men's Health Institute and is active on several non-profit Committees and Boards. Through practical and professional experience he is familiar with treatment issues and needs of PLWH, particularly within the African American community. *Sam Saul* is a retired physician who now serves as clinical professor of medicine at UCSF. He is a charter member of Bay Area Physicians for Human Rights and a founder of the Gay and Lesbian Medical Association.

The bylaws require that the CARE Council have a majority of HIV+, self-disclosed members. At this time it has 20 (one short of a majority), so the Mayor will be asked to prioritize HIV+ nominees in his appointments. *MC* also announced that the Council needs to vote on *Leanne Monferdini's* nomination as Health Commission representative to the Council, and for that of *Allan Meyer* as Title IIIb representative.

MJW asked if an outreach effort was made to Marin and San Mateo counties in the search for nominees. *MC* replied that the Membership Committee did not conduct a formal advertising process in this round of nominations, but chose from the pool of applications already submitted and those forwarded by the Mayor. *MJW* noted that there is currently very little representation on the Council from the other counties, and encouraged the Membership Committee not to overlook the importance of that representation. *MC* said that one of the stated goals of the Membership Committee is to increase outreach and advertising to those areas.

***MC* moved that *Barry Savage*, *Chris Bohm*, *Dorothy Bartolomucchi*, *Johnnie Norway*, *Donald Bliss*, *Steve Oxendine*, *Sam Saul*, *Allan Meyer* and *Leanne Monferdini* be submitted to the Mayor for consideration for appointment to the Council.** The motion was seconded and the motion passed **[2]**.

Bylaws Changes

MC explained that the proposed bylaws changes can now be discussed and voted on because they have been on the table for the required 30 days. He recalled that the three main changes are: 1. modifications to the membership categories 2. provision of an alternate for the state representative and 3. implementation of term limits for Council membership. The Committee also made a language change to #6, which will read (if approved) "local public health agencies and/or their designees".

MC explained that the purpose for the change in membership categories is to bring the bylaws into line with the new CARE Act legislation. He noted that removal of categories does not imply that they are not important to the Council, but aims to give the Membership Committee greater flexibility in deciding what

categories the Council lacks at any given time. The new language to be added to the top of section 2 was taken directly from the CARE Act.

MJW asked if the new membership category list meets all Title II requirements, as well as Title I. *JB* explained that Planning Councils active in Title II consortiums are only required to meet Title I membership requirements.

MC **moved to accept the proposed changes to sections 1 and 2 of the bylaws.** The motion was seconded. *MC* clarified that the addition of a provision for the state representative to be allowed an alternate intends that the alternate be approved by the Membership Committee in advance of meeting attendance.

JB said that the language change should provide the *option* for an alternate, although availability of an alternate can not be guaranteed each time the state representative is unable to attend. He also noted that an alternate would probably attend very infrequently, and would therefore not be knowledgeable on the Council's issues. *JB* expressed his opinion that for these reasons the provision of an alternate would not solve the problem of low state representative attendance. He suggested that a better solution would be to apply a lower attendance requirement to the state representative than is applied to the rest of the Council.

TL suggested that the Council vote on the bylaws sections separately, rather than combining sections 1 and 2. The Council agreed, and a roll call vote was held on the notion to support the proposed language change to section 1 of the bylaws [3]. The motion passed.

MC moved to approve the proposed changes to section 2 of the bylaws, excluding the final paragraph. A roll call vote was held and the motion passed [4].

MC moved to approve the proposed changes to the final paragraph of section 2, which refers to the provision of an alternate for the state representative, with the provision that the Membership Committee work with *JB* on how the change could be most effectively implemented. The motion was seconded and a roll call vote held [5]. The motion passed.

For section 3 of the bylaws, *MC* forwarded a slightly different language modification than that originally proposed, in order to add clarity: "the term of office on the Planning Council shall be one three-year term, without possibility of reappointment". Besides this change. the modifications originally proposed for the section are to remain the same.

BC asked the reason for setting term limits. *MC* explained that they aim to insure that new members, with different ideas and experience, are continuously added to the process, and to eliminate the inefficiency of annual reappointment.

JB asked how this bylaws change would impact current Council membership. *MC* replied that a motion has also been proposed by the Membership Committee, to be addressed separately, that outlines the way in which members who have already served over three years will be addressed. *JB* expressed concern that the motion, which states that all members who have served two or more years must submit their resignation within one year of the passing of this bylaws change, will cause the Council to lose valuable experience and historical perspective. *MC* recalled that at the last Membership Committee meeting it was suggested those members who will leave be asked to create a written history of the CARE Council. He also noted that if the motion passes, the Membership Committee will orchestrate resignations of the 11 members to whom it would currently apply so that they do not leave the Council simultaneously. *JB* expressed the concern that the language of this motion would allow those who have served less than two years to serve a full three more, while those who have served as few as two years would be required to resign within one more. *TC* clarified that the motion would allow a total of three years, including time already served, to those who have been on the Council for less than two years, while those who have served longer than two years would be allowed only one more. *JB* noted that historical perspective is

invaluable in many decisions, and not every question that may be raised regarding past situations can be codified in a document.

NN suggested that all language pertaining to the implementation of the bylaws be contained within them--including the effective date of the motion regarding resignation of long-term members--rather than outlined as a separate motion.

TS acknowledged that the current practice of reappointment each year is disruptive, but reiterated *JB's* concern regarding the loss of important historical perspective. He noted that long-term membership has not caused any specific problems, and expressed the opinion that members should be welcome as long as they are willing and able to comply with attendance regulations. *TS* suggested that the proposed term limits be extended to five years.

SL expressed the opinion that the Council currently has a good mix of time and experience, and agreed with *TS* that no problems have arisen due to length of membership. He suggested that the disruption caused by constant reappointment be addressed in a different way.

TC explained that one goal of setting term limits is to insure that the Council continues to reflect the demographics of, and be highly attuned and responsive to, the community it serves. The reasoning is the same as that behind the membership list changes: a body which addresses a non-static epidemic should not itself be static. He acknowledged that historical perspective is important, but expressed the opinion that a dynamic body which continues to be reflective of its target population can be institutionalized. *SL* said that the Council membership, as currently organized, is not static.

Leanne Monferdini expressed the opinion that term limits are a way to guard against long-term membership of someone who does not benefit the group and its process. She also noted that with the loss of historical perspective there is a danger of repeating mistakes. *LM* suggested that an Historic Advisory Committee be created and attended by interested parties whose terms have ended but who wish to continue their support of, and contact with, the Council. Members of this Committee could be invited to attend a specified number of Council meetings each year, but not allowed to vote, and the group could be responsible for creating an historic summary of the Council, its bylaws, various important decisions and the reasoning that went into them, etc. *TC* expressed strong support for this idea.

KW expressed opposition to the proposal to set term limits, on the grounds that the Council currently has a good mix of long- and short-term members, all of whom bring an important perspective. He also noted that a required three-year commitment will significantly reduce the number of applicants.

TL explained that the only parts of the bylaws that can be addressed at this time are those that include the proposed changes, because those are the parts that were noticed. Therefore, according to parliamentarian regulations, only the language that the proposal removed or added to the bylaws can be modified. Regarding addition to the bylaws of the separate motion concerning implementation of the proposed change around term limits, *TL* noted that because that was not noticed in advance it can not be voted at this meeting. For the same reason, the modification to the proposal language which *MC* suggested earlier ("one three-year term without possibility of reappointment") can not be accepted at this time.

JC reiterated the concern regarding loss of historical perspective on the Council. He also expressed the opinion that an Historic Advisory body with no voting power would not be able to replace long-term membership in terms of the ongoing perspectives and experiences brought to the group. *JC* also noted that it would be very difficult for San Mateo and Marin to find new representatives every three years who are willing to make a three-year commitment. He suggested that if term limits are set they not be applied to county representatives.

DJ suggested that rather than creating an Historic Advisory Committee for "retired" Council members, the Council begin to place more weight and value on Committee work and recognize that Committee meetings

are open to non-member participation (although only Council members can vote at the Committee level, as well). She noted that Committees usually attempt to reach decisions by consensus, which gives non-members a greater voice there than at the full Council.

BS expressed support for term limits and noted that discontinued membership does not have to mean discontinued contact and participation in the process.

MJW noted that the Council currently includes good representation of members from all different time periods throughout the life of the body, who bring diverse perspectives and knowledge to the group. She asked what problem the setting of term limits aims to solve.

JB requested that the Membership Committee provide information on the various lengths of membership currently present on the Council. He suggested that the Council member directory include each member's date of original appointment.

SL reiterated the importance of historical perspective and knowledge in the planning process. He also requested that the Membership Committee address current Council demographics and representations and insure that further proposals will effectively fill gaps.

KB observed that the CARE Council is not likely to exist beyond a few more years, making this point moot.

TC noted that this Council has historically struggled with under-representation of young people, and admonished the group to value vision for the future as much as it values historical perspective.

MC said that the Membership Committee will discuss the issues raised at this meeting and return with another proposal for the shaping of Council membership.

TC said that the proposed changes to attachment A will not be addressed tonight, but referred back to the Membership Committee. The proposed change to article 4, section 3, simply brings the language in that section into line with the Council's past decision to strike language around the specification of an AIDS Office co-chair. *MC* moved to accept that language change. The motion was seconded and a roll call vote held [6]. The motion passed.

Leave of Absence Requests

MC announced that the Membership has received requests for leaves of absence from *Brett Vanbenschotten* and *Danny Joe*. He moved that both requests be granted. The motion was seconded and a voice vote was held. The motion passed unanimously.

Attendance Review

MC announced that the Membership Committee recently conducted the attendance review for the second quarter of 1998, and several members were found to be out of compliance with attendance requirements. All of the identified members are HIV+, but had not notified the Committee whether their absences were due to illness (for which there is a provision in the bylaws). *MC* said that a change must be made to hold HIV+ Council members more responsible for notifying the Membership Committee when meetings are missed due to illness. He read a new policy which the Membership Committee will be implementing, and which was included in the pre-meeting mailing. This policy requires HIV+ members to call a designated staff person within one week of a meeting that is missed due to illness and request that their absence be recorded as excused. *MC* volunteered to act as the contact person who is to be notified of illness-related absences until the Council staff person is identified.

New Member Orientation

MC announced that the new member orientation is tentatively scheduled for May 8. He requested that those who have been asked to prepare presentations for the orientation give him outlines of their materials by May 1, and said that each presenter will be given ten minutes.

VC announced that the women of Hazel Betsey House wished to thank *TL* for lending them his Office 97 program.

DJ announced that *BC* had to leave the meeting early, but completed a proxy form for any further votes.

WC apologized for arriving late to this meeting and explained that he was recently appointed to the AIDS Scientific Advisory Council, which informs the mayor on the state of HIV research. His first meeting with this body overlapped with the CARE Council meeting today. On the advisory Council, which addresses many issues covered by the CARE Council as well, *WC* hopes to represent the interests of CARE.

VIII. Allocation of Additional Funding

DJ summarized for new members that the 1998 prioritization was based on a worst case scenario, with a subsequent contingency plan for the allocation of funding above the worst case amount. This contingency plan outlined the allocation of funding, by percentage, to specific service categories within an integrated service delivery system. The two service categories which were not included in that integrated system were food and home health, to which the Council did express a desire to allocate greater funding. At the last Steering Committee meeting *Michelle Long Dixon*, of the AIDS Office, reported that $180,000 are free for allocation to food and home health, but the subcategories therein to which it is to be awarded must be specified by the Council. In its review of utilization data the Committee found that both food and home health are currently above their contracted units of service.

Deb Self, program manager of the SF Food Bank, advocated for the allocation of additional funding to the food category. She noted that the Food Bank and Project Open Hand serve the target populations specified during last year's prioritization process, specifically multiply diagnosed low income women and transgendered people. *DS* distributed a list of SF Food Bank member agencies that serve multiply diagnosed CARE clients.

VC asked how the populations served by the SF Food Bank differ from those served by Project Open Hand. *DS* explained that the Food Bank supports 350 programs in San Francisco that provide food to

homeless and very low income people. The Food Bank's CARE contract includes two sections: solicitation of food donations which are given to programs that target HIV+ people; and the emergency food box program, which caters mainly to recently diagnosed PLWH who do not yet know about the ongoing food providers in the city. Project Open Hand is one of the main organizations in the first section of the contract.

DJ explained that the Council previously agreed that additional funding for food and home health would be split evenly between the two. The subcategory to which this funding would be awarded within the food category is food bank/meal delivery. For the home health category, *DJ* recalled that funding was originally cut due to information indicating underutilization. However, current data show that the category is actually exceeding its contracted units of service. The Steering Committee proposes that the $90,000 slated for the home health category be held until the monitoring of utilization data is completed and a decision regarding the future of the home health contract is finalized.

JB asked if there is a target date for the home health funding to be re-addressed by the Council. *DJ* said that it will be re-raised during 1998, but it is at this point too soon to set a date. *JB* observed that funding allocated too late in the fiscal year is difficult to utilize by the deadline, and suggested that a target date be set. *NN* recalled that the Steering Committee decided to keep the home health issue open on its agenda so that new information can be addressed as it becomes available.

KW suggested that the Council assume the funding will eventually be allocated to home health, pending the necessary information, and the Steering Committee report back to the full Council only if problems or concerns arise.

***DJ* reiterated the Steering Committee's proposal: $90,000 of additional funding will be allocated to the food bank/meal delivery subcategory within food, and $90,000 earmarked for the home health category, to be allocated pending Steering Committee review of the contract and utilization data.**

TC recalled that when the Council decided to allocate additional funding to food and home health in equal amounts it specified that that funding was to be incorporated into the integrated service RFP, which the current proposal does not reflect. He requested that the Council ask the AIDS Office to provide an implementation plan for how the $90,000 for food will be association with the integrated service proposal(s) that are eventually funded through the current RFP process.

DJ noted that although the AIDS Office has not reported back to the Council on the RFP and why food and home health were not included, it can be assumed that there was a reason for their omission.

Jim Illig, of Project Open Hand and the Contractors Association, noted that the food category received a $200,000 cut through the last prioritization, and so this $90,000 is not additional funding, but a reduction of the original cut. He also recalled that the Council decision to which *TC* referred was worded "Any additional funds will be put toward supplementing an integrated approach to CARE services". *JI* said that both the SF Food Bank and Project Open Hand already use an integrated approach to providing services. *WC* recalled that one reason for the original cut to funding for food providers was the Council's lack of understanding of how funding to that category benefits the identified target populations. During the prioritization process the Council decided that more information was needed on the subject, including needs assessments, target populations, etc. That information remains unavailable. *WC* expressed the hope that in the coming prioritization process greater information regarding the food-related needs of PLWH and how they are met by providers in the food service category will be made available.

DJ restated the motion. *Russ Zellers*, of the AIDS Office, suggested that the specification of $90,000 for each category be omitted in case the addition funding is not exactly $180,000. *DJ* agreed to change the motion to specify that 50% of additional funding will go to each category. A roll call vote was held and the motion passed [6].

KW asked that in the future the AIDS Office staff regularly report to the Council on exactly how its directives are implemented.

IX. Steering Committee Report

WC recalled that at the last Council meeting the issue of Planning Council Support was referred to the Steering Committee with the request that recommendations be reported back to the full body. This issue includes a decision on how to fill the Council's staffing requirements and implement the Consumer Rights Advocate function. *WC* noted that one concern for the Evaluation and Assessment Committee is how the data needed for the prioritization process will be gathered this year. In its discussions of this issue, the Steering Committee decided that a person or office should be designated to coordinate fulfillment of the Council 's support needs. It has been reported to the Steering Committee that the Support Center, which is currently providing technical support, will not serve this function. Another consulting group, called Interactive Associates, has been identified as a possible alternative.

WC explained that the Steering Committee feels that someone needs to serve as coordinator until a permanent person or group is found, to orient that person to the needs of the Council and serve as liaison until the process is worked out.
The Steering Committee has decided to propose that *Tom Calvanese* serve this function. It discussed the question of conflict of interest, and through discussions with the AIDS Office discovered that technically there is no conflict. *WC* reiterated that a great deal of work needs to be done to support the Council in its prioritization process, and it is unfair for that burden to fall on the shoulders of Council members, as it did last year. He said that *TC* has the skills and Council knowledge to do that work, as well as to orchestrate implementation of the Consumer Rights Advocate office. *TC* would be viewed as the CARE Council Support program manager.

DJ added that the goal is for the Council to have a permanent support staff person who is hired through an open, competitive process. However, because that process will take some time, and the Council needs support and coordination immediately, it is propose that *TC* serve as interim staff. The goal would be to mount the permanent system within 4-6 months.

TL noted that this issue is not noticed as an action item on the agenda, and asked when it was decided that it should be a vote. *DJ* explained that the Council referred this issue to the Steering Committee at its last meeting, and this is the Committee's response. *TL* asked if this position would be full or part time. *DJ* replied that the specifics and accountability of this position will be worked out by the Steering Committee, which will report back to the Council.

Leanne Monferdini asked if this position will be posted. *DJ* replied that the permanent position will be posted, but the interim one will not. *LM* cautioned that hiring a co-chair without an open application process may cause concern in the community. *WC* noted that that concern was considered by the Steering Committee, which felt that it could be alleviated by requesting the Council's permission to proceed with the plan as proposed. He reiterated that this would be a temporary position for *TC*, while the permanent support system is being developed.

KB spoke in support of the Steering Committee's proposal to hire *TC* as interim Council support staff. *TL* also expressed support for the plan forwarded by the Steering Committee, and noted that because the issue of Planning Council Support was referred to the Committee last month it should be able to implement the plan without holding a vote.

KW suggested that *TC* temporarily step down as co-chair during the time that he is serving as support staff, in order to keep his role on the Council clear at all times. *WC* noted that several past co-chairs have filled more than one role on the Council, and expressed the opinion that *TC's* dual charge will not create a

conflict. He also explained that technically *TC* will not be contracted by the Council itself, but by Interactive Associates.

DJ noted that in serving this function *TC* will have conflicts of interest on some issues, and will conduct himself in accordance with the conflict rules that apply to all members in Council discussion.

VC expressed support for the proposal on the grounds that Planning Council Support needs to progress and *TC* would be a good person to coordinate it. *LO* voiced his agreement.

LM reiterated her concern that being hired by the CARE Council could put *TC* in an awkward position. She also noted that if conflicts of interest become a problem his voting privileges could be suspended for the duration of his employment as Council staff.

TS expressed concern regarding the hurried tone of this proposal, and recalled that past decisions that were hastily made have frequently turned out to be ill advised. *WC* replied that this issue has actually been in discussion for several months.

JC expressed support for the proposal, and for *TC* in particular to fill the interim position. He also noted that the Council could be criticized for not holding an open application process, although at this point there is clearly not enough time to do so.

DJ reiterated that this proposal does not involve hiring a Council staff person, but identifying a member of the body to serve as interim consultant to the agency which will eventually serve as support provider. This is an important distinction. *WC* added that it was clear to the Steering Committee that *TC* would best fill this position for many reasons, and expressed the opinion that the community will understand that.

TL expressed support for the Steering Committee's recommendation, and listed three issues which may cause concern in the community: 1. the hiring of a consultant without an open bidding process, 2. someone who is personally receiving CARE dollars also holding a vote on the Council, and 3. a Council consultant also serving as meeting facilitator.

TS asked the co-chairs to explain their interactions with HRSA and the AIDS Office in researching the feasibility and allowability of this plan, and whether it was discussed with the City Attorney. *WC* replied that there was no need to consult the City Attorney. He explained that the legislation around Planning Council Support allows the Council much more freedom in its implementation than in the contracting process for other categories. *WC* already outlined this plan for *Norm Nickens* and *Michelle Long Dixon*, both of the AIDS Office, neither of whom expressed discomfort with it.

DJ said that because there seem to be no strong objections to this plan the Steering Committee will proceed with its implementation, but address the three concerns outlined by *TL* and consult whomever is necessary to alleviate them.

TC explained that it was not his idea to serve as interim consultant to the Planning Council Support process, and he was originally opposed to it. He said that in his 2 1/2 years on the Council his primary objective has been to make it truly a community body that reflects the needs of those it serves. He expressed appreciation for the confidence that the Council has expressed in his ability to serve this function, and noted that several valid concerns have been raised as well. *TC* explained that he has already outlined a plan for this position, which includes meeting with representatives from Interactive Associates this week, and with Committee chairs to work on drafting an implementation plan for how to provide the Council with the support it requires through the prioritization process. He encouraged those with remaining concerns to contact him.

DJ reported that *Dick Pabich* has requested that the Council provide the Mayor's office with a prioritization of services for General Fund restitution in case funding from that source becomes available.

In particular, *DP* asked for support from the Council to request restitution from the city of the $850,000 mental health cut. It has been agreed that as cuts are made through future Council prioritization decisions, services receiving those cuts will be prioritized and that list forwarded to the Mayor. *DP* has also been assured that the Council would support the use of General Fund money to restore the $850,000 cut to CARE funding for mental health services.

X. **New Business--none**

DJ reminded the Council that there will only be one meeting in May, on the 18th, which will be held at 25 Van Ness Ave.

XI. **Adjournment: 7:35**

ATTENDANCE AND VOTING RECORD

P=present; A=absent; E=excused; L=leave of absence: Y=yes; N=no; B=abstain; R=proxy

	1	2	3	4	5	6	7		1	2	3	4	5	6	7
James Abrams	A							Diane Jones	P	Y	Y	Y	Y	Y	Y
Kirsten Balano	P	Y	Y	Y	Y	Y	Y	Susan Karp	P	Y	Y	Y	Y	Y	
Marianna Balquiedra	P	Y	Y	Y	Y	Y	Y	Tony Leone	P	Y	Y	Y	Y	Y	Y
Troix Bettancourt	A							Steve Lew	P	Y	Y	Y	Y	Y	Y
Jeff Byers	P	Y	Y	Y	Y	Y	Y	Norm Nickens	P	Y	Y	Y	Y	Y	Y
Virginia Cafaro	A							Lisa O'Connor	A						
Tom Calvanese	P	Y	Y	Y	Y	Y	Y	Loras Ojeda	P	Y	Y	Y	Y	Y	Y
William Carter	P						Y	Ron Reynolds	A						
Bart Casimir	P	Y	Y	Y	Y	Y	Y	Alissa Riker	P	Y	Y	Y	Y	Y	Y
Veronika Cauley	P	Y	Y	Y	Y	Y	Y	Nilda Rodriguez	P	Y	Y	Y	Y	Y	Y
Fernando Chavez	A							Joy Rucker	A						
Michael Chesek	P	Y	Y	Y	Y	Y	Y	Matthew Sharp	P	Y	Y	Y	Y	Y	Y
John Conley	P	Y	Y	Y	Y	Y	Y	Thomas Sinclair	P	Y	Y	Y	Y	Y	Y
Mark Dunlop	A							Laura Thomas	A						
Miriam Farooq	A							Brett VanBenschoten	A						
Gene Gowdey	P	Y	Y	Y	Y	Y	Y	Kelly Wallace	P	Y	Y	Y	Y	Y	Y
Danny Joe	A							Mary Jane Wood	P	Y	Y	Y	Y	Y	Y

HIV HEALTH SERVICES PLANNING COUNCIL

April 27, 1998

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

DRAFT

I. **Call to Order: 4:40 p.m.**

II. **Member Introductions:** New members introduced themselves.
Steve Oxendine - African-American Men's Health Institute.
Allen Meyer - San Francisco Community Clinic Consortium. Replacing JG.
Dorothy Bartolomucci - Secretary, Women's AIDS Network.
Lee Ann Monfredini - San Francisco Health Commission.
Johnnie Norway - Board Member, Bay Area Young Positive.

III. **Roll Call [1]**

IV. **Approval of the Agenda:**
(LT) Under new business of the agenda, Item 8: the decision to vote to cancel the full council meeting in May on Memorial Day was moved and seconded. The decision was called to a vote, unanimous in favor of canceling the meeting. There was an acknowledgment that May might need another scheduled meeting.
(DJ) Asked that under Item E the staff report be added.
(TC) Asked (BC) to amend the agenda.
(BC) Inquired as to the new meeting place.
(DJ) Reported no success in finding an alternative meeting place.

V. **Approval of the Minutes:**
(TC) Minutes of March 23 meeting were approved. They have just been received by AIDS office staff and are now being mailed out. New members were asked to update both the roll call and mailing lists.
(NN) Will mail form 700 to all new members which must be completed for the State.

VI. **General Announcements:**

A. (LT) Announced her absence last week was due to the AIDS Lobby Day event she attended in Sacramento. She provided an update as to what occurred there regarding the state budget and relevant legislation. In terms of the state budget, for this year the governor's budget will be able to accommodate the AIDS Drug Assistance Program that has been the subject of Council focus. The Senate Budget Subcommittee will be meeting this afternoon, but since it is the Governor's budget request the Council is supporting, she thinks money will be allocated this year to meet the needs of Californians with HIV.

Regarding state legislation, the proposed bill calling for mandatory reporting of HIV infection in the State of California will not be put forward by the California Medical Association and legislative sponsor Don Ferada, thanks to the advocacy of various groups smaller than the State. Currently, the only legislation pending on the initiative of HIV surveillance is one by Phil Midken of San Francisco that advocates a pilot program to identify HIV infection rather than reporting it.

One of the other issues concerns criminalization of HIV transmission; potentially those bills that would make it criminal to transmit HIV through unsafe sex have been killed.

Also, SFAF will be moving its offices on May 8th to 1 6th Street on the corner of 6th and Market. There is a large conference room available there for future meetings.

B. (LO) Walden House wants money from NIH for a research grant. Support from the CARE Council would be greatly appreciated. (TC) Asked a letter be drafted and presented for review at the next Steering Committee meeting. The application is due May 10.

C. (LT) In the past the CARE Council has written letters of support for programs applying for grants from the government. The Council should continue being supportive of other agencies in their attempts to get federal money for the city. Given the time line, the Co-Chairs were asked to sign a letter. (TC)(LiO)Agree they would both be willing to sign once the letter is given to them.

D. (SL) Given the Council is trying to track what Federal dollars are coming into the city, it should be informed of all evaluation projects.

E. (NR) Positive Match for positive women and their children which is in the final stages of building acquisition, is being fought aggressively by the community due to apprehension about the presence of people with AIDS there. Their final meeting will be held tomorrow from 5 to 6:30 at 770 Golden Gate. Support for this program of women with HIV and their children is necessary and welcome.

F. (MD) The Redevelopment Commission Meeting convening tomorrow will vote on HOPWA funding for that program which has already been approved by the loan committee. The neighborhood has been adamant in ceasing that funding. The Council is invited to attend and show support for HOPWA. It is extremely important the vote pass. If the vote does not pass, this initiative will not be realized.

G. (TC) Everyone should be aware that the tactics of the members of this neighborhood are extremely aggressive in that they have consistently delayed this meeting with the knowledge that the longer they delay and with the outcome of this vote (if negative), HOPWA may not be able to make the deadline for this particular property.

H. (WC) Wanted everyone to realize the ramifications and repercussions of HOPWA not receiving these funds are serious and damaging to all AIDS programs and their funding. He proposed to discuss this problem tomorrow night.

VII. Public Comment

(TC) Asked for a show of hands of those individuals not associated with the Council as members of the Public. No one raised their hands to voice comments at this time.

VIII. Committee Reports

Planning Committee Report:

(LT) The Planning Committee has been working on a variety of things this Spring in preparation for the Prioritization process of this Summer. The first is fulfilling the Federal legislative mandates to account for dollars that are used in San Francisco to pay for other similar services. CARE dollars bring with them a mandate that it is a funding of last resort. In order to demonstrate that, in the grant there has to be an account for other dollars that are available and being used in a similar way.

The Planning Committee has also taken seriously the desire of the Council the last to do a better job of integrating HIV specific and non-specific services, particularly in the areas of primary care, mental health, and substance abuse. The Department of Public Health submits dollars for similar services, often serving the same population as the services the CARE Council funds. The Planning Committee has taken these particular areas of primary care, mental health, and substance abuse services and met with the Department of Public Health to review the community planning processes and bring this information back to the CARE Council. This includes the goals of assessing what other funding is available in these areas, looking for overlap and opportunities for integration, as well as the possibility of better planning for the future within these groups. They began with substance abuse and are now bringing this information back from that meeting. This information will continue to be made available. They would like everyone on the Council to keep this information in mind once the Prioritization process begins.

(DJ) Passed around the spreadsheets used in the last Prioritization process regarding substance abuse. There are substance abuse services for people with HIV that are not CARE funded but funded by Community Substance Abuse Services. And there are substance abuse providers that care for HIV positive, HIV negative, and HIV unknown within that same program. At the frontline there is an integration of services that have a commonality, but the funding is not integrated at all. The current funding structure does not work when integrating services. The Community funded services do not consider CARE funding as part of their picture. The main objective of integrating services with primary care at the center is to get the substance abuse programs to figure out a linkage to other CARE funded

services, in particular to primary care. And with the client being at the center, it is important to strengthen that linkage. This category is among the most funded by CARE.

(LT) Thanked (DJ) for her presentation and preceded to introduce Mike Seiver and Charlie Morimoto, community co-chairs of the Treatment on Demand Council.

(CM) There is currently a lot of misunderstanding surrounding the T on D Council. In October of 1996 there were two issues the board of supervisors focused on.
(MS) The first issue was the use of methamphetamines within the Gay Community. And the other dealt with the use of carburetor inhalants among children. The T on D Council made a presentation to the Health and Public Safety Committee on the Board of Supervisors discussing both stimulants and inhalants. During that presentation, the goal was to prevent drug of the day media coverage and having to shift all T on D attention to what was read, seen, or heard. The outcome indicated that chasing a drug is not a very good strategy.

(CM) T on D wanted to know what the expenditures would be by not treating substance abuse. Their research came up with 1.7 billion dollars. The resolution of the presentation was initiative 10/55/96 of the Board of Supervisors for Treatment on Demand which would urge officials to pass a budget that would bring treatment on demand for the indigent. Throughout this process, T on D discovered its importance in developing a community planning process. It found through Care and HIV prevention legislation, the CARE Council was the only mandated community model. In February of 1997, the Treatment on Demand Planning Council was appointed with 40 members.

One of the problems T on D had with substance abuse is most of the Federal funding was given directly to the agencies and would not go through the city system, so grants would not be made aware of until after they expired. T on D began to meet and had public hearings in three specific areas of San Francisco. At these hearings, it was determined to develop a system that is Treatment on Demand. The mission of the first steps plan was submitted to the Health Commission to both inform them of the T on D Council system as well as to justify the 4 million dollars the Health Commission planned to submit. The media caught wind and misinterpreted the dollars to an exorbitant amount. As a result, in anticipation, other agencies began to cut back on their dollars.

It is important to address the different needs of a diverse population that seek substance abuse treatment. The Care Council provides an excellent model on how to achieve this, which T and D hopes to emulate in some ways in order to avoid becoming overly bureaucratic.

(MS) The process of forming the T on D Council has always been grounded in the community, beginning with its focus on the use of crystal methamphetamines within the Gay community. T on D currently tries to represent a diverse group of people. The initial goal was not to just expand the treatment capacity of the organization, but also to ensure the CSAS system is culturally competent. T on D felt that one of the reasons for consistent drop-out of substance abuse treatment was a lack of cultural competency. Another concern was the holistic approach , people do not come divided into categorical funding streams. Someone who has mental health problems, substance abuse problems, and HIV is one person; not three. T on D wants to work towards integrating all departments of the DPH. The next issue was family focus. San Francisco has the highest child removal rate in California, a major reason of which is the substance abuse of parents. One of the major priorities has been to develop programs that allow parents to keep children while in treatment. T on D wanted to develop new engagement strategies for anyone who needs help easily. The way the treatment system functions now forces the interested individual to run into several barriers, mostly due to cultural competency, harm reduction, the development of new strategies, and intervention.

Harm reduction is a major focus for T on D. In the past, if a person relapsed during substance abuse treatment, they were automatically expelled. T on D would like to develop harm reduction strategies that

continue to treat even though a person is unwilling to abstain from drug use. This type of strategy is fairly revolutionary within substance abuse treatment. Other themes have been to look at the whole system to determine the gaps between, for example, detox to outpatient, where people tend to fall through the cracks.

T on D would also like to address accountability in terms of how the facility is providing treatment, what is the success and failure rate, what is the drop-out rate, and the level of cultural competency. As the system is asked to help multi-diagnosed individuals, staff is ever increasing and T on D is interested in providing better training to those staff.

Wrap-around systems was another area of focus T on D was interested in establishing. They want to develop a system that includes both more treatment slots as well as employment opportunities. T on D currently has about 6 million dollars to create new treatment and it has been very time consuming addressing all proposals. The first priority is to deal with young people who have both alcohol and drug problems. Another priority is to have a system that helps the elderly with substance abuse problems as well as help for multidiagnosed individuals who are sent to several facilities, each addressing an individual problem.

T on D is concerned about the lack of residential programs for monolingual Latinos and also want to establish treatment services for Lesbians. They are looking forward to the National Association of State and Territorial AIDS directors to do consulting.

(CM) Recently T on D met with NASTAD to discuss the communication process across different councils to develop comprehensive planning for the entire population. (CM) referred to the report that was submitted to the Health Commission. T on D did not have family focus residential centers. To remedy the list of services they did not have, they developed a community planning process. (CM) passed out DPH Community Substance Abuse Services Organization Chart. The themes coming from the T on D office are, "Access, Integration, and Standardization". To assist with integration, T on D has looked to the providers to provide that information and are testing on small populations.

(MS) People inquire as to why HIV is not a priority for the T on D Council and the assumption is CARE dollars take care of that. The disappearance of CARE dollars would facilitate HIV becoming a pressing priority.

(LT) Surprised to find after reading through the T on D report, people with HIV are not listed as a target population. After discussion, it was understood T on D sees the CARE Council as covering all funding for PLWH. For the future, CARE would like T on D to see people with HIV as part of the whole continuum of people they are serving.

(CM) The primary reason people with HIV were not seen as part of the target population was due to the gaps that occurred with servicing so many different people with different needs. Anywhere there was funding already, the Council left the responsibility to the appropriate organization, and T on D saw CARE Council as filling in the gap for people with HIV.

(LT) Feels there are a lot of opportunities to move forward as both Councils share a consistent set of values around what services should look like. In terms of where to go from here, it is important to look to common providers, where the money is overlapping, where the providers are integrating, and leveraging dollars. Servicing the youth and developing programs for both HIV and substance abuse are high priorities for both Councils.

(LiO) After having worked with substance abuse treatment for four years, she knows that women with HIV have an extremely difficult time in treatment. It is important to create a strategy that is sensitive to women in an atmosphere that is male-dominated and to track the progress of those women.

(CM) While it is true T on D began with a model that is co-ed because it was cheaper, the issues of domestic violence and prostitution prove programs for women only are needed.

(MaS) The initial reason T on D didn't make HIV a target group and looked to the Council for that was simply for the numbers. The CARE Council had funding to target HIV where T on D had funding for substance abuse. T on D looked to the CSAS budget and was able to determine that so much of CARE dollars was separated into four separate categories; primary care, mental health, housing, and substance abuse. The two most funded categories are residential short term care and residential long term care. The focus was to utilize this money in terms of services, in the best possible way. T on D wants those people who are not covered by CARE funding to be covered. Cultural competency should also be centered around AIDS. One of the issues addressed in the last prioritization process was the willingness to train CARE workers regarding cultural competency.

(MS) Are there any reasons other than institutional, women may not be able to access services?

(LiO) Other than basic reasons of a lack of female sensitivity and the ratio of one woman to every ten men, there are no specific reasons.

(LT) In San Francisco, there is one woman with HIV to ten men with HIV in this city's population. Thus the ratio of women to men in treatment may simply reflect the local demographics of the disease.

(MaS) Are there any HIV prevention dollars going into the CSAS budget?

(MS) There are prevention dollars in the CSAS budget, although not a huge part. We are now looking forward to DPH and CSAS integrating and collaborating on an RFP. The prevention dollars available are for the youth rather than adult.

(AM) One area that may be of interest between DPH and CSAS is a joint program of monitoring and evaluation.

(TC) Regarding residential treatment, is T on D looking at accessing housing dollars and pulling that into the integration? Unfortunately, housing is often a motivating factor of people reaching out for treatment.

(CS) That is really a departmental issue to be handled by Mark Trotz. T on D has had dialogue with DHS to create a tie between housing and substance abuse services.

(MS) T on D agrees housing is a very serious issue. When T on D began, funding was for residential treatment programs. They soon realized funding would be insufficient. One of the strategies has been to set up substance abuse facilities within the housing projects themselves, in order to combine both substance abuse treatment and housing dollars. Presently they can't afford to provide the many residential programs that are needed.

(TC) It is a good idea to contemplate alternative forms of housing as residential treatment programs are very expensive. In support of harm reduction, T on D may be able to utilize public housing funds provided the program follows a harm reduction model.

(DJ) In approaching everyone with the question of what would be done if CARE dollars were to disappear, the resounding answer is panic. There is a need to begin making plans because it may happen in a couple of years. What is the priority of this money for community substance abuse and mental health? She discovered, housing is a problem more for the CARE Council to do in part of its funding stream. But once CARE money is gone, it automatically becomes everyone's problem again. So it is important to get opinions from everyone regarding what their individual priorities will be when that happens.

(CS) Expressed his agreement.

(LoJ) What is T on D doing to address the needs of Spanish speakers who are seeking treatment?

(CS) There is currently an RFP for Latino speaking male adults.

(MS) We increased the funding for council for outpatient treatment in the Mission.

(KW) The CARE Council is expected to enter every dialogue prepared to offer funding. Has T on D received dollars regarding the NASTAD communication.

(CS) There are no NASTAD dollars, there has only been dialogue. Barbara is the CARE representative on the T on D Council.

(MS) The next concern is how to link mental health issues with those of substance abuse and HIV.

(WC) What's next and where do we go from here?

(MS) It is essential the two Councils continue to meet and try to pull together the various areas of both systems.

(WC) The grant for CARE funding is due October 1st and the Prioritization process begins within the next two months, so all work must be done within that timeframe.

(CS) It is important this work be done over the long term because cross-planning and determining the vehicles of both Councils take time.

(VK) Is there an opportunity for CARE to review the CSAS budget? And what about transgenders who don't fit into any category and treatment for them?

(CS) There will be an opportunity to look over the CSAS budget. And transgenders are considered one of the priority populations of T on D for new service.

(LT) Calls for a break at 6:15 PM of 15 minutes.

(TC) Calls meeting to order.

(LT) Next Planning Committee meeting will be May 7th from 3-5 PM, in the same building. Mental Health Services and the Department of Public Health will be attending.

IX. **Housing Committee Report:**
(TC) Joy Rucker is the other co-chair of the housing committee, and they are also seeking new members. The goal of the Housing Committee is to present recommendations to the Council that are more thoughtful and more productive than last year. The confusion surrounding HOPWA affected decision making in confusing ways. They have put together a workplan to both avoid past confusion and develop some recommendations for Prioritization.

At the last meeting there was discussion surrounding the update of the five-year housing plan. There have been a number of meetings held and that report is now being finalized. It may be ready to be presented here on May 18th. In terms of integration, there was discussion regarding CARE and HOPWA money and how it fits into the city's overall budget for housing. The most comprehensive housing group, CHAS(Comprehensive Housing Affordability Strategies) will have a presentation made to them by this

committee concerning HIV housing related issues. That will be part of what is reported back to the council during the May 18th meeting.

A consultant has been hired by the Redevelopment Agency to review services in the licensed facilities (that RA covers, while CARE monitors the nursing services there). This person has provided suggestions and recommendations as to the organization of those services. This committee will review that report which is now being finalized and present that information to the Council on May 18th.

There was also a meeting with Dick Pabich in the Mayor's Office on HIV and housing. From that meeting there are some specific recommendations being made about accessibility to housing subsidies, raising fair market rent, and increasing access to housing resources. (TC) asked Dick to hold any more information for the next meeting and the Housing presentation. Joy was going to be here tonight to make a pitch for new members and anyone who might want to co-chair as she is interested in stepping down as Chair but, will continue to sit on the Housing Committee. The next Housing meeting is May 5th from 11 to 1PM and during that meeting the committee will be discussing the relationship of CARE and HOPWA funding to the rest of the world and formulating any recommendations to the Council for the Prioritization Process.

(KW) Would like to come to meeting but can't attend from 11 to 1 in the afternoon.

(TC) Dates and times have been a consistent problem for this committee. This time and date is being stated because it was what was settled on at the last meeting.

(VK) If given enough advance timing, she can reserve the conference room at Hazel Betsey House.

(MF) Indicated the interest in joining the Housing Committee.

X. **PWA Caucus Report:**
(NR) Still waiting for information regarding AIDS services. Many of the people who attend our meetings are HIV+ and need refreshments. As it is not in the budget, the Council should find a way to provide this comfort. People are still coming to this committee with questions regarding housing and they are being referred to the proper committee.

As for updates, the Derrick Silva lack of heat issue has come back as well as a lack of fire alarms for the hearing impaired.

Mike Petrelis offered to do press releases for the Council and was told it is beyond the scope of the Caucus committee to authorize that. There is a need for women in the PWA Caucus. The next meeting will be held on May 6th from 5 to 7PM at the AIDS Office on the third floor. Orientation of new members will be conducted on May 8th from 9 to 12 noon at the AIDS Office.

(TL) Orientation is best for new members who have not sat on planning groups before.

(NR) The Caucus sent a letter to the Mayor requesting the reappointment of BS.

(AM) Requested the orientation be videotaped.

(AM) NR mentioned a survey?

(TL) Review: In the past there has been an attempt to identify unmet needs by community solicitation, through a specific Community Input committee which metamorphosed into the PWA Caucus. In January, it was decided to make community input not the sole responsibility of the PWA Caucus, but a responsibility for all. Last month the Caucus brought forth a letter requesting feedback from all the committees. It was met with no response. Activities need to be put together soon.

(DJ) Admitted the Council had forgotten, and wanted the PWA Caucus to recirculate the letter and attach it to the next mailing.

(MaS) Suggested for next meeting, an opportunity on the next agenda to discuss community input.

XI. **Evaluation Committee Report:**

(AR) Distributed a written report of a work plan where the focus will be discussed at next meeting and asked new members to take a good look at it. Their next meeting will be held at the AIDS Office from 5 to 7 PM on Monday in the Conference Room on the 5th floor.

(FC) Would like to do an evaluation of the meeting, but can't attend on Monday's. Is there any possibility at changing it?

(WC) Agreed to discuss rearranging the meeting so new members could come.

(MS) Concerned about community input and needs assessment. Prioritization is fast approaching and there is no good needs assessment for this year.

(WC) Reported that he attended the last Evaluation Committee meeting. The Grant is due on October 1st and Prioritization begins within the next few months. Due to delays in the RFP system, that process has been put off a few months. June 1st is when those projects under that RFP will be funded. Given that those projects will begin in June and the grant is due in October, the question is what kind of assessment could be obtained for programs that just began? Not a very good one. The outcome was to look to the grant and see what was required and simply fulfill that requirement, then evaluate the impact of our changes the following year. The solution may be to conduct specific needs assessments in different categories rather than a blanket one.

(TL) The next PWA Caucus meeting will discuss community forums.

(VC) When there is a larger space, public will come. When there is a smaller space, no one shows up.

XII. **Staff Reports:**

(TC) The Council does not officially have staff support, but has received some technical support with AIDS Office and Polaris through the Support Center. His goal is to create the reality of a staff and it will prove to be a real challenge. The Council currently has a contract with Polaris to cover the minutes and to provide the refreshments through June. If there are questions, call (TC) at 621-7712. Right now, the Council should have the capacity to realize its goals; like analyzing needs assessment. (TC) is also looking to find a better space for Council meetings.

In terms of needs assessment, he met with members of the Epi staff of the AIDS Office. There are two sets of information that can be made available to the Council in time for the June presentation. These include client level interviews and utilization of information from URS for 1997. (TC) is trying to put together all of the committee workplans to make a complete one for the entire Council in the future.
He is also assessing ways to increase the efficiency of dollars in contract with the Support Center. He has also met with Positive Resources regarding recruitment strategies to hire people with HIV for technical assistance. The responsibility of the Consumer Rights Advocacy Program has been given to him and he will work with the chairs of the PWA Caucus to do an RFP, which will have to be done quickly. Throughout this process, a job description has been drafted for the person who will eventually take over this position.

(VC) Asked TC if he would like help in finding a new meeting place. His answer was YES.

(JB) Epi staff will give us an overview on the status of the epidemic in SF now? Last year's lacked substantiality.

(TC) It is important to remember the request or there will be little info. And asked JB to discuss what is meant by more substantiality.

(BC) There needs to be a definition of what harm reduction is to CSAS that is in accordance with the Council. Also, CSAS wants to know what to do with individuals who relapse while in residential treatment programs. (BC) will continue to report to the Council.

(TC) Asked if there were any further comments or questions from the AIDS office whose reply was no.

XIII. **Adjournment:** 7:35 PM

ATTENDANCE AND VOTING RECORD

P=present; **A**=absent; **E**=excused; **L**=leave of absence

DRAFT

James Abrams	A	Susan Karp	P
Kirsten Balano	P	Tony Leone	P
Marianna Balquiedra	P	Steve Lew	P
Dorothy Bartolomucci	P	Allen Meyer	P
Don Bliss	P	Norm Nickens	P
Jeff Byers	P	Johnnie Norway	P
Virginia Cafaro	P	Lisa OiConnor	P
Tom Calvanese	P	Loras Ojeda	P
William Carter	P	Stephan Oxendine	P
Bart Casimir	P	Alissa Riker	P
Veronika Cauley	P	Nilda Rodriguez	P
Fernando Chavez	P	Joy Rucker	A
Michael Chesek	A	Matthew Sharp	P
John Conley	P	Thomas Sinclair	P
Mark Dunlop	P	Laura Thomas	P
Miriam Farooq	P	Brett VanBenschoten	P
Gene Gowdey	P	Kelly Wallace	P
Diane Jones	P	Mary Jane Wood	P
Danny Joe	L		

- Wayne Salcido leaving the State — going to H/SA - to manage Jessie H. & IV.
- Steve Lew is leaving the Commission; going to the Empire to

mid August 17,000 homeless or marginally housed (1500 HIV+ = 10% of total epidem.
72% not on drug therapies of 17,000

Tony Anderberg T1 & T2 T1 = 35% IDU & MSM/IDU; 60% MSM

Not accessing care
1) NO HIV svs.
2) " address homeless
3) bad exp., previously
4) told they are ineligible
5) believe " " "
6) lang./cult barriers
7) fear of conseq. of being identified

Harm reduction
- Rx neg. w/ phys.
- better crack pipe
- plan. alterm. to using
- sex neg. practice
- needle ex.
- referal to Cannabis Buying Club

HIV HEALTH SERVICES PLANNING COUNCIL

May 26, 1998

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

HIV Health Services Planning Council
Minutes of Meeting
May 26, 1998

DRAFT

(Prepared by Polaris R&D)

I. **Call to Order:** 4:45 PM
II. **Approval of the Agenda:** The agenda was approved unanimously.
III. **Approval of the Minutes:** Minutes of April 20 were approved unanimously.
IV. **Roll Call [1]**
V. **General Announcements:**

A. (DJ) Announced the group was short of a quorum so all agenda items that required a vote would be postponed.

Thanked all members for their attendance as this special meeting was called last week.

The minutes for April 20 will be up for approval and mailed in time for the next Planning Council meeting in June.

B. For the meeting to be held June 15, the AIDS Office Conference Room will not be available, and all committee members should be on the look out for an alternative space to be listed with the next agenda schedule arriving by mail.

C. (WC) Presented HRSA publications; Substance Abuse and the Epidemic and Priority Setting and Resource Allocation, for the benefit of all Council members. He also provided all interested Council members with copies of the Street Sheet.

VI. **Public Comment:**

Steve Meyers through his translator introduced himself as a deaf client under the care of UCCD (UC Center on Deafness). He attended the Planning Council meeting to express his concern at the cuts being made in mental health services. He announced that he has relied heavily on the services at UCCD for two years and how impending cuts would negatively affect him. He hopes the money and the services are restored to aid the hearing impaired with mental health problems like himself.

(DJ) inquired as to whether UCCD is aware of any cuts that have been made. As far as the Council is concerned there has been no notification of which services and which organizations who will no longer have funding. It is important to know if there are letters that have gone out to agencies of which the Council is uninformed.

Cari Deloa of the AIDS Office explained, UCCD has not officially been told of any cuts to be made regarding their agency as the only organizations informed of funding being cut are programs including food and other services instead of long and short term psychotherapy and mental health programs.

Tim Moore, a client of the UCSF Center on Deafness is losing his hearing as a result of the HIV/AIDS virus. He addressed all members of the Council with a letter asking the question, "why much needed mental health services to people with terminal illnesses are being cut?" It was

followed with a brochure on HIV/AIDS - related hearing loss. He asked the Council to please reconsider restoring the funding cuts made to mental health services.

Ruth Hughes has been a Human and Gay Rights Activist for over thirty years. She asked the Council to return to looking at the whole picture and the whole person. Mental health services are necessary for the health of the entire person. There are people out there, especially people of color who need help and are unable to receive it. The Council should make it a priority to find compromises and make them.

(WC) explained mental health cuts were due to a decreasing budget. Unfortunately some cuts had to be made. (DJ) related that mental health is not only necessary but important to the Council and it is doing its best to find compromises and address the issues of those who need those services. There is agreement the dollars are available, the question is who picks up the bill.

Laura Ferren of the HIV Contractor's Association wanted to enlighten the Council that contrary to what was stated at the last Council meeting, that she as well as many other contractors have been in attendance since the last Prioritization process.

VII. Unallocated/ Unexpended Funds Vote Discussion:

As members arrived (DJ) announced there were enough Council members for the necessary quorum to continue with the agenda. She then asked (WC) to provide a summary of the Council deliberation regarding Unallocated/ Unexpended funds at the last meeting and to indicate where that deliberation ended.

(WC) The last meeting centered around a motion to reopen the previous funding decisions on mental health. This motion failed, with 17 members opposed and 11 in support.

(TC) Did a summary of funds from the AIDS Office. There were 3 different pots of dollars that were referred to. The current motion on the table concerns dollars that were unspent for fiscal year 97-98 which is approximately a million dollars. The exact amount will remain unknown for approximately a month or so. In February, when the original decision was made concerning these funds, the best estimate was $275,000.

(DJ) Asked Michelle if there wasn't a time line she could provide for determining the final amount of unexpended funds from fiscal year '97 -'98. Michelle replied the deadline was the first of June. (DJ) wanted to remind the Council the AIDS Office would have to petition HRSA to be able to rollover these funds into this fiscal year.

(TC) During Prioritization for this fiscal year 98-99, the decision was made for the first $400,000 in unspent dollars of this year's budget would go into direct emergency financial assistance.

(DJ) Clarified that the amount of money (TC) just referred to is the same amount of money taken off the table in Laura's motion, passed at the May 18 meeting. The current motion on the table concerns unspent dollars for fiscal year 97-98.

(WC) Clarified further the amount of unbudgeted expenses in this year's budget is equal to $664,000.

(NN) Made a motion to the Council to direct the AIDS Office to request through HRSA to release fiscal year 97-98 rollover funds. Those funds shall be used for non-ADAP drugs and up to $850,000 to restore cuts in long term therapy mental health services while the rest be used for direct emergency financial assistance.

(VC) Seconded the motion.

(NN) The idea is to request from HRSA rollover funds for non-ADAP drugs and the amount is roughly $224,000. To restore mental health services cuts, the amount needed is $850,000. And the rest (from rollover funds of up to 1.4 million dollars) would be used for direct emergency financial assistance. These emergency funds do not take into account the emergency funds the Council has already set aside.

There was confusion as to how the motion (NN) presented would affect the motion previously on the table. The outcome revealed the motions concerned the same dollars in rollover funds for fiscal year 97-98, however (NN) provided the Council with a range of numbers for clarification.

(DJ) What's different about these funds is that they are not intended to be utilized in a short period of time but rather rolled over into the budget for this fiscal year 98-99, therefore increasing this year's budget.

(TC) The four areas in which major cuts were made in this year's budget (FY '98-'99) were pharmacy, home health, case management, and $850,000 in mental health. A decision was also made that if more money was received over the baseline budget, some of those dollars would be directed into an integrated service RFP. $96,000 was redirected into home health which has yet to be allocated, $144,000 was redirected into case management, $192,000 into mental health. This last figure went into the integrated service RFP in the form of psychiatric consultation. As a result the actual cut for mental health services is $657,239.

(TC) Wanted to remind the Council of the decisions made during Prioritization if there was the possibility of more money such as this million dollars. He then gave a list of those priorities: pharmaceuticals, in-home health, housing subsidies ($2,000,000), redirecting mental health services into youth; crisis intervention, early intervention and prevention for HIV dementia.

The controversy surrounding the vote on unallocated/unexpended funds concerns the understanding that severe cuts have been made in the area of mental health and it is imperative to do everything possible to restore those cuts, however, during the last Prioritization process certain decisions were made to redirect any additional money to the budget in other areas. If the Council decides to vote the way of the motion which is to put rollover funds into non-ADAP drugs, mental health services, and direct emergency financial assistance; the question remains as to what happens to those projects decided upon during the Prioritization process and who will pay the bill after fiscal year 98-99 (ending in February, 1999) for those mental health services.

Mitch Katz of the Department of Public Health stated that the DPH will assume responsibility for funding these mental health services after the fiscal year for the Council ends in February, provided the Council redirects these rollover funds in the estimated amount of $850,000 in that area.

(DJ) commented on the difficulty of trying to follow the first priority of the Council which is to help those individuals who are not being served while at the same time being seen as devaluing mental health. When the primary objective is to serve severe need populations, it occasionally requires taking dollars from one area and putting it in another. The dilemma is not that mental health isn't important, it is how to identify the necessary funding. There is agreement by both the Council and the Department of Public Health in finding a compromise to restore cuts to mental health services and provide the necessary funding.

(AM) Made a motion to rollover 2/3 (the remainder of the 98-99 fiscal year) of $657,239 to mental health services, the amount leftover from $850,000 after the $192,000 restored to the integrated service RFP in the form of psychiatric consultation. This motion would not affect any of the other categories of the previous motion. (TS) Seconded the motion.

Break: 6:35PM -- Return: 6:50PM

(DJ) Made a motion to vote on the amendment presented by (AM). The motion is carried.

The amendment presented by (AM) to replace $850,000 with 2/3 of $657,239 does not carry by a 2/3 vote. **Vote [2].**

After this vote there was discussion on the rules of conflict of interest. The outcome was any member is allowed to vote any way they choose and it is the responsibility of the Council to follow proper procedure in contesting that vote and at which time if it is found the voter does have a conflict of interest, his vote will not be counted. (TC) will look into the proper procedures in contesting a conflict of interest and bring that information to the Council at the next meeting.

The vote to rollover funds into non-ADAP drugs (approximately $224,000), $850,000 to mental health services with the remainder into direct financial emergency funds carried by 2/3 vote. **Vote [3].**

VIII. **Committee Reports:**

A. PWA Caucus Report:

(TL) Directed everyone to the PWA Caucus position statement on the back of the agenda. Before discussing the position statement, (TL) stated that the PWA Caucus has been working on the RFP for the Consumer Rights Advocate and the Community Input Meetings. (TL) wanted to remind everyone that community input is the responsibility of the entire Council and everyone is expected to participate. The next step is for everyone to identify which groups they would like to participate with in the next thirty days. The following is a list of groups already in place.

Johnnie Norway, Michael Chesek: Youth
Mark Dunlop, Tony Leone: Housing

Nilda Rodriguez, Lisa O'Connor: Women
Tom Calvanese: Tenderloin / Homeless

The start date for community input is now July 1 instead of June 1. Participation is necessary for all Council members, as it is important for the people to be heard.

The discussion then turned to the complaints brought to the attention of the Council by Derek Silva Community Residents. It is the agreement of the entire Caucus that something needs to be done concerning Derek Silva Community as the AIDS Office or the Human Rights Commission were unable to resolve issues. (TL) then referred to the PWA Caucus position statement which focuses on the special housing needs of those living with AIDS, and presented a motion directing the AIDS Office to include contract language concerning minimum standards for the provision of heat in CARE funded housing facilities.

A letter written by Michael Baumgarten, a man with AIDS and former Derek Silva resident, was read to the Council detailing the experience of living there. Michael Baumgarten died the night before.

The Council took turns discussing concerns for the residents of Derek Silva and the need to respond to the request for intervention on their behalf. The motion concerning minimum standards for the provision of heat in CARE funded housing facilities was passed unanimously. **[Vote 4]**.
The next PWA Caucus meeting will be held June 3 at 5PM.

B. Planning Committee Report:
Due to a mistake made in the agenda, the Planning Committee was not scheduled to present at this meeting.

C. Membership Committee Report:
Tabled for the next meeting.

IX. AIDS Office Report:
The AIDS Office presented an update on the RFP process in response to a request from the last Steering Committee meeting. The RFP solicited for eight separate categories: housing, financial services, psychiatric consultation, training and education, dental care, a combination of case management, peer advocacy; and treatment advocacy, transportation, clothing and household goods vouchers, and integrated services. Integrated services were solicited under one category while the other seven were solicited under other services. Forty-six applications were received from twenty-six separate agencies.
To date three awards have been made in the areas of housing, training and education, and money management.

A separate review panel convened for each category. An attempt was made to balance the panels with consumers, field experts, diverse ethnicities, and representative genders. The result: 28% HIV positive, 35% people of color, 35% women, and 3% transgender.

Challenges ranged from finding available panel participants and the difficulty in covering several applications to cancellations and no-shows.

There is an attempt to have all awards made by the end of the first week in June.

X. **Planning Council Staff Report:**
Tabled for the next meeting.

XI. **New Business:**
Tabled for the next meeting.

XII. **Adjournment: 7:45PM**

DRAFT

ATTENDANCE AND VOTING RECORD

P=present; A=absent; E=excused; L=leave of absence; Y=yes; N=no; B=abstain; R=proxy

	1	2	3	4		1	2	3	4
James Abrams	P	N	Y	Y	Susan Karp	A			
Kirsten Balano	P	N	Y	Y	Tony Leone	P	N	Y	Y
Marianna Balquiedra	A				Steve Lew	A			
Dorothy Bartolomucci	P	Y	Y	Y	Allen Meyer	P	Y	Y	Y
Don Bliss	P	N	Y	Y	Lee Ann Monfredini	A			
Jeff Byers	P	N	Y	Y	Norm Nickens	P	N	Y	Y
Virginia Cafaro	P	N	Y	Y	Johnnie Norway	P	Y	N	Y
Tom Calvanese	P	Y	N	Y	Lisa OiConnor	P	Y	Y	Y
William Carter	P	Y	N	Y	Loras Ojeda	P	B	N	Y
Bart Casimir	P	N	Y	Y	Stephan Oxendine	P	N	Y	Y
Veronika Cauley	P	N	Y	Y	Alissa Riker	A			
Fernando Chavez	P	Y	Y	Y	Nilda Rodriguez	A			
Michael Chesek	A				Joy Rucker	A			
John Conley	P	B	B	Y	Matthew Sharp	P	Y	Y	Y
Mark Dunlop	P	N	Y	Y	Thomas Sinclair	P	Y	N	Y
Miriam Farooq	P	Y	N		Laura Thomas	A			
Gene Gowdey	P	N	Y	Y	Brett VanBenschoten	A			
Diane Jones	P	Y	N	Y	Kelly Wallace	P	B	B	Y
Mary Jane Wood	P	N	Y	Y					

HIV Health Services Planning Council June 15, 1998

NOTE NEW LOCATION
1675 California Street @ Van Ness (Wells Fargo Building)

Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	
III.	Review and Approval of Agenda	
IV.	Review and Approval of Minutes of 3/23/98 & 4/20/98	
V.	General Announcements	
VI.	Public Comment	4:35
VII.	AIDS Office Report -- Progress Report on 1998-99 plan	4:45
VIII.	Co-chairs Report	4:55
IX.	Committee Reports	
	A. Steering Committee – Prioritization Schedule	5:00
	B. PWA Caucus 1. Committee Report 2. Review Panel Recommendation regarding HIV Consumer Rights Advocacy Program Award (VOTE)	5:05
	C. Housing Committee Report 1. Committee Report 2. Recommendation regarding Unallocated Home Health Funds (vote next meeting)	5:20
	D. Evaluation Committee Report	5:25
BREAK		5:30
	E. Planning Committee / Evaluation Committee *Mental Health Services Presentation*	5:45
X.	New Business	
XI.	Adjournment	7:30

Up-coming Meetings:

June 22, 1998 – Planning Council, 1675 California St. @ Van Ness (Wells Fargo Bldg.), 4:30 – 7:30 PM
June 29, 1998 – **Evaluation and Assessment**, AIDS Office, 5th Floor Conference Room, 5:00 – 7:00 PM
July 1, 1998 – **Housing**, AIDS Office, 5th Floor Conference Room, 10:00 AM – 12:00 PM
July 1, 1998 – **PWA Caucus**, AIDS Office, Suite 330-A, 5:00 – 7:00 PM
July 2, 1998 – **Planning**, AIDS Office, Suite 330-B, 3:00 – 5:00 PM
July 10, 1998 – **Membership**, AIDS Office, 5th Floor, Training Room A, 9:00 – 11:00 AM
July 13, 1998 – **Steering Committee**, AIDS Office, 5th Floor Conference Room, 5:00 – 7:30 PM
*July 20, 1998 – Planning Council, Location to be announced, 4:30 – 7:30 PM
*July 27, 1998 – Planning Council, Location to be announced, 4:30 – 7:30 PM

The site is fully accessible, and assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to the Council Members, are available for inspection and copying. For further information, call the Council's staff, 415-554-9136.
Minutes of Meetings are tentative until formally approved by the Council.

SF HIV Health Services Planning Council

DRAFT

June 15, 1998 Meeting
1675 California Street
San Francisco, CA
4:30 - 7:30 PM

0. Prior to Roll Call, a sign-up sheet was circulated to allow the public to sign up to address the council during the Public Comment. Approximately 25 non-council attendees were present.

1. Call to Order was made by William Carter. He reminded the attendees that the Public Comment sign-up sheet was available. He offered copies of the agenda and the Request For Proposal (of HIV Consumer Rights Advocacy Services). He then indicated Michael Coughlan, minutes-taker, to call the roll.

2. Roll Call was made and is recorded below. *Only absences or excused are marked.* (The initial Roll Call did not yield a quorum; as the meeting progressed, a quorum was achieved):

James Abrams	Absent	Susan Karp	Absent
Kirsten Balano		Tony Leone	
Marianna Balquiedra	Absent	Steve Lew	Absent
Dorothy Bartolomucci		Allen Meyer	Absent
Donald Bliss	Absent	Lee Ann Monfredini	
Jeff Byers	Absent	Norm Nickens	
Virginia Cafaro	Absent	Johnnie Norway	
Tom Calvanese		Lisa O'Connor	
William Carter		Loras Ojeda	
Bart Casimir		Stephan Oxendine	
Veronika Cauley		Alissa Riker	
Fenando Chavez		Nilda Rodriguez	Absent
Michael Chesek	Absent	Mathew Sharp	Absent
John Conley		Thomas Sinclair	
Mark Dunlop	Excused	Laura Thomas	
Mariam Farooq		Brett VanBenschoten	
Gene Gowdey	Absent	Kelly Wallace	
Diane Jones		Mary Jane Wood	Absent

3. Review and Approval of Agenda (A request was noted from TC that many people were here to make presentations regarding mental health services and that they might be heard out of sequence from

the agenda to assure adequate time.) Section E of the Committee Reports was moved forward to follow the Co-Chairs Report and to call the break following Section B of the Committee Reports. A motion was made and seconded with unanimous "aye's" and no abstentions.

4. **Review and Approval of Minutes** of 3/23/98 and 4/20/98 was not possible due to a lack of a quorum; postponed until later in the meeting.

5. **General Announcements**
TC noted that a Title I conference call on 6/16 3 PM EDT re application guidance from Health Resources Services Administration (HRSA) on grantees. He offered flyers and the 800 number to call to listen only, as San Francisco is a non-interactive site for this call.

TC reported the resignation of two council members, *Danny Joe and Joy Rucker.* Their resignation letters were read aloud. (attached) Reasons cited included difficult commutes (DJ) and an imminent death in the family (JR).

6. **Public Comment** was initiated by WC
- Ron Reynolds, representing the Larkin Street Youth Center, presented a letter that his organization wanted the co-chairs to sign (see copy attached). The co-chairs had already seen the letter and allowed him to describe the theme of both the letter and the organization (comprehensive services, most-critical needs public, youth, mental health issues, homeless issues, substance abuse issues, collaboration). WC opened for questions by the council. BV noted that other organizations like this have come (and received) support from the council. The letter was signed and returned.

4a. **A quorum was achieved** and the council returned to review and approval of the previous meetings' minutes. **(see above)**
3/23/98: Please correct misspellings of some council members' names (VC)
4/20/98: (VC) Item G: note "constructed but not on-line" ; numerous misspelled names and words (satellite for candlelight, etc.); WC requested that current minutes-taker make appropriate corrections; request was acknowledged.
Voice vote: 3/23/98 unanimous "aye's", no abstentions
Voice vote: 4/20/98 unanimous "aye's", no abstentions

6a. **Public Comment** (cont.)

- Gilbert Criswell, requested a letter be sent to the mayor's office to expedite availability of section 8 housing in the Presidio and Treasure Island. WC noted the request.
- Michael Petrelis, (AKA www.accountabilityproject.com), USA Today published an article today about protease-induced fat deposits in patients (the first mainstream newspaper to do so); distributed an article from Board Member Magazine (based in Wash., DC; attached) about the above Web site above and sunshine laws. He warned that DC Republicans are quite amenable to the tone of the article. He reminded the council that a letter he submitted "nine long months ago" had not been responded to. He believes the lack of response is a validator of his original inquiries as to accountability of non-profit boards and his particular powerlessness to effect change (which originally caused a "brouhaha" in the press at the time the letter was sent.)
- Ramone Martinez and Gilbert Pickett, of Gay Positives, were denied funding for youth outreach. They pointed out that several programs noted in the proposal were ignored and purported to not be included and that numerous people of color-specific agencies received funding while no youth-specific agencies were allocated any funds. (not attached)

7. **AIDS Office Report** (1998-99 Plan) (Russ Zellers) (no written document)
- Rollover dollars total: $1.673 M
- Budgeting of rollover: 234k non ADAP drugs, 850k L/T mental health services, 589k direct emergency financial assistance.
- RFP - all but a small amount ($2,600) has been allocated to integrated services; the remainder is available for treatment advocacy
- Integrated service allocations (8-month amounts; no housing subsidies; they were given to the AIDS Foundation):

Continuum:	471k
St. Mary's:	510k
Asian Pacific Isl. Wellness	179k
Haight-Ashbury clinics	287k
Lyon-Martin	255k
Bay PAC	36k
Mission Neighborhood H.C.	130k
Native Amer. Health Ctr.	62k
S.O.M.A. Health Center	35k

- Dental services - not yet awarded
- Housing Services - went to the AIDS Foundation

- Financial Services - went to Lutheran Social Services (373k)
- Case Management/Treatment Advocacy/Peer Advocacy:
  Mission Neighborhood Health Center (72K)
  Glide Foundation (92k)
  TARP (119k)
  Catholic Charities (47k)
  Asian P.I. Wellness Center (127k)
  Shanti Project (228k)
- Training and Education - went to Living Well Project (100k)
- Psych. Consult - went Instituto de la Raza (42K) and AHP (146k)

More detailed and summary information will be distributed at next week's meeting. There may be changes, subject to appeals.

No funding was slated to agencies serving just youth. BV was offended, particularly since youths were considered a severe-need population last year in the planning process. WC noted that the documentation of these decisions must be reviewed as the gap between what the priorities are and allocation of funds must be closed.

8. **Co-Chairs Report** WC asked if Mayor's liaison has any input for the council; the liaison declined.
TC (referring to an information sheet (attached)) pointed out that the under-serving of youth (noted in the sub-category mental health) might be addressed using the $850k that will be re-instated in the mental health budget. TC excerpted from the grant the reference to mental health services and that contract negotiations with the agencies would proceed with both issues (mental health and youth) strongly emphasized. The gap of several months (Feb.-July) in city versus council funding would also be addressed.

9e. **Committee Reports** Introduced by Diane Jones. Specified that discussions will deal with the future, not past years. The evaluation and planning committees worked together to arrive at the need for these mental health presentations and the current state of resources.

Jo Ruffin, from Community Mental Health Services at the DPH, issued a packet of materials (not attached)
- with the DPH 32 years; two-pronged resource to HIV community:
  - expertise evolved from ongoing funding and response and
  - expertise funded by external sources for uninsured clients
- moving into managed care (via healthcare reform mandates) has been spotty and scattered across the states; little movement has been

noted in the area of mental health, however. Current status in California has a two-pronged access:
1. State-funded "Fee-for-Service" @ $35/hour (billable directly to the state); not heavily used as rate is low in perception of most providers, and
2. County-funded mental health funds for the severely mentally ill.
The DPH has received a mandate to integrate these two sources ("consolidation") and has been trying since April by enrolling providers willing to be paid through the fee-for-service arm.

The criteria for admission into the system appears on the attachment; some of the criteria peculiar to the HIV community are not adequate for admission; certain combinations of mental health and substance abuse diagnoses are also not adequate (particularly AIDS dementia). We are trying to develop a single standard of care for all people who are indigent, but funding is not assured (we requested the $ through the health commission but are severely underfunded; we got $1 MM of out requested $5 MM.)

We want to build a cross-referencable database between our system and providers (none exists right now) to coordinate activities. Only half of the providers are certified for Medical; we must take them into the system and then work toward certification. Ryan White money has the same certification requirements as Medical. We will return to the Health Commission to push for expanded funding toward this integration and certification.

DJ noted that residential care is still being evaluated (as it absorbs so much of the substance abuse dollars, particularly in today's real estate market). Is there a similar consideration for the costs of residential care in the DPH model? Ms. Ruffin acknowledged that these issues (substance abuse, mental health and residential care) are intertwined but that the bulk of the thinking behind their work does not pre-suppose the necessity for residential care, nor does funding exist to set residential care as a practical first step. ("Chateau Agape" was lost due to funding shortages, she reported)

Laura Thomas commented that one of the side-effects of people living longer with HIV is the more pressing need for mental health, substance abuse and residential services, even as the funding is dwindling. Ms Ruffin noted that public discussion for funding was coming up this Saturday. She acknowledged that the residential arm of mental health services is not her specific discipline and that the

historical logic of sending clients into residential care was to divert them from stressed resources of acute hospitalization. New medications appear promising and may alter the equation around the need for residential care.

The baseline $35/hr is the reference point for continued state funding, with half paid by Medical and half by the state. Some services need more than the standard and are basic to the HIV community. Getting funding to cover such services is still another issue.

WC asked for insights on value-added services the council should consider above and beyond the current fiscal mechanism by which the DPH operates. Ms. Ruffin's response was to consider the expense of the expertise being brought to bear through the DPH which is not covered by the $35/hr structure currently in place. Another way is to independently fund services that the DPH system cannot sanction due to its cost structure. WC requested that Ms. Ruffin remain accessible as the planning process continues. She acknowledged.

BREAK CALLED (TIME: 6:25)

Jim Dilley, AIDS Health Project, reporting on data collected through a survey of 12 agencies providing mental health services.
- over 20 years of experience; types of clients served: long-term/short-term clients (document not attached)

Some special points about the survey:
- collected Jan.-March, 1998
- mental health definitions are not universal, interpretation not uniform
- not comprehensive in terms of costs and services provided
- about 1,500 clients, largely male, most in 20-44 age group
- youth coverage weak; no agencies listed are youth-focused
- mostly white (61%), with African Amer. (15%) and Latino (15%)
- housing situation suggests that 75% are in "unstable" housing
- 58% have monthly income < $660, 90% < $1,200
- 59% on MediCal, Medicaid, or Medicare; with no ins.: 25%
- L/T at risk of poor adherence to RX regimen: 35%
- total population with high suicide risk: 30%

The mandate to move these patients to managed care is no panacea. Services will be restrictive. Reimbursement rates will be low. HIV experience among providers is low. Nineteen percent have substance abuse problems (complicating treatment and eligibility). And 11.5% of patients have HIV dementia.

Barriers to access: ignorance, unwillingness to detox, stigma of MH, unready to face the situation, restrictiveness of environment, multiple diagnosis clouding the issues.

WC asked the council to keep in mind the necessity of "tagging" mental health issues as a component of other needs and issues. Gil Criswell wanted to know if there was any breakdown of the treatment regimens of these twelve agencies that might help the planning committee in funding (ex. conservative, progressive, radical approaches to mental health and substance abuse). There was no response to the question.

David Paisley, operator of the AIDS Nightline, addressed the council for the purposes of making clear the need for "complementing" mental health services of the overall effort. (ex. Unusual hours, approaches accessed more easily by the hesitant/timid/closeted/youth, those not needing ongoing care, but need a sounding board). WC asked the cost of the program. Response: $100k/year, serves over 2,000 revolving clients with 20-30 minute phone call overnight. Total client count: ~4,000. Cost per unit: between $20 and $25 per client.

Guy Vandenburg, Continuum, added that complementing services and access points such as daycare, walk-in mental health services and substance abuse services, social welfare services, etc. He encouraged MH professionals to continue to think "outside the box" of their discipline in considering hard-to-access people in need.

WC was strongly encouraging these presenters to continue their approach to the council and augment it with documentation on philosophy, utility and cost. While improved over last year, the council needs to hear more.

10. Summing Up

Steering Committee Prioritization Schedule, TC (see attached) - note changes from original (esp. AIDS Office section to 7/27 meeting)

- any business not related to prioritization must be shelved to make the deadline (August)
- chief complaint last year was "too many meetings"; note limited number of meetings this time.
- the council needs more time to discuss what is presented; tonight was poor in that there has been no time for discussion within the council.

1. We will meet each day of the first week of August to discuss the four major service categories and the other support services and the Counties. Recommendations will be made during each of these meetings. All recommendations will be consolidated in the successive Monday meetings through August.

DJ noted that the council will be more firm in its prioritizations this year, leaving less room for revisits and appeals. The length of time in subsequent council meetings should provide adequate time for points to be made.

PWA Caucus - TC said there may be more to report at next meeting.
HIV Consumer Rights Advocacy Program - no response to the RFP; deadline extended to July 10; delay to next meeting
Unallocated Home Health Funds - recommendation will be rephrased and presented next week.
Housing Committee Report - will be part of the Housing presentation scheduled for next week.

11. Meeting Adjourned (7:40 PM)

DRAFT

HIV HEALTH SERVICES PLANNING COUNCIL

June 22, 1998

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

HIV Health Services Planning Council — Minutes of Meeting, June 22, 1998

Call to order: 4:45 PM.

DRAFT

Roll Call [1]

I. **Review and Approval of Agenda:** A request was made to extend the time for item #6 under the Housing Committee Report to 15 minutes. There were no objections.,

Review and Approval of the Minutes of 5/26/98. *MJW* requested that future motions be written out in their entirety. She mentioned that on page 4 of the minutes under item #8 the minutes are not reflective of what the Council voted on. The actual motion asked the AIDS Office to make sure that housing contractors maintained temperature requirements. Also, the language of the minutes should not be inflammatory. *TL* will supply the language for the motion. *NN* noted that there were numerous procedural changes that needed to be made to the minutes. *MJW* requested that corrected minutes be seen again. *TC* moved that corrected minutes be sent to Council members, and be calendared for approval at the next meeting.

General Announcements:

A. *Mary Jane Wood* reported on the Title II Working Group meeting. The State Office of AIDS is thinking of consolidating several of their programs - particularly case management, early intervention, consortium funding and viral load funding - combining those funds and distributing them throughout the state. The state has decided it will take at least two years before it will complete this consolidation. In the meantime she is sitting on the Resource Allocations Committee which is trying to come up with funding priorities for the entire working group. The question arose whether current counties that are receiving money should be held harmless. This is an important question in San Francisco and San Mateo counties. If funding is consolidated and distributed statewide, these counties would lose money. The discussion of a "hold harmless clause" or a "maximum reduction clause" needs to be addressed in the Resource Allocation Committee. *TC* asked how often she could bring reports back? *MJW* said the Title II Working Group meets quarterly, and the Resource Allocation Committee has telephone conferences every one to two months. *TC* asked if there will be another report before the end of prioritization. *MJW* replied that there would not.

B. *Laura Thomas* distributed an action alert urging people to contact members of the House Appropriations Subcommittee on Labor, Health and Human Services, and Education regarding tomorrow's funding decision for the Ryan White CARE Act programs to protect Title I and Title II funding. She also announced that she is resigning from the CARE Council effective the end of this month. She has taken a job at the Department of Public Health's AIDS Office and will continue to work closely with the Council. She has been on the Council for eight years and will continue to attend Planning Committee meetings.

C. *Tom Calvanese* distributed a letter sent to the Council by David Paisley, Program Director of the AIDS/HIV Nightline San Francisco Suicide Prevention providing information and an overview of how they administer Crisis Services.

Public Comment: *Adrian* from the AIDS Legal Referral Panel announced that they get about 3,000 calls a year and around a fifth of those calls are housing related. They have just hired a full time housing attorney who will be able to help people with housing issues.

I. **AIDS Office Report:** Progress report on the 1998-99 plan. *TC* announced that the Council got a preliminary report last week concerning the implementation of the Request For Proposal (RFP) process. This is a more detailed follow-up report. *Russ Zellers*, of the Dept. of Public Health's (DPH) AIDS Office, reported that they have the awards from the RFP for the Integrated Services and the Case Management Peer Advocacy and Treatment Advocacy programs. He distributed information on the awards. He was asked where additional funding would come from, and how much it might be. *Russ* said it would most likely come from the General Fund but that some might come from any left over CARE funds, and that they did not know how much it might be. He was asked how youth services will be funded and responded that they go back to the people who applied for youth service dollars and ask them to reapply. There was one formal appeal of the funding decision on Case Management, Peer and Treatment Advocacy for youth services. The award will be based on alternative solicitation. The AIDS Office sent a letter last week regarding the awards. Tomorrow they plan to fax service providers to indicate funding changes and to work with those agencies who have had funding cut to transition clients to other programs. They contacted agencies to see who had the capacity to take on additional clients. They need to determine if there are enough resources to meet the needs of current clients. He was asked if there is a goal for when they'll complete recertification and said they have a meeting tomorrow to try to get all the contracts through quickly. *WC* asked if anything was left out of the figures presented to the Council. *Russ* said that the dental and vouchers award letters have not gone out and that they will report on those at the next Council meeting. He was asked where perinatal care is included. *Russ* said it is integrated in the Lyon-Martin

funding since subcontractors are not named in this list of funding. *TL* asked what type of vouchers were being referred to. *TC* responded that the vouchers contained in the RFP were for household goods and transportation.

VIII. **Co-Chairs Report:** No report was made.

IX. **Committee Reports:**

A. **PWA Caucus Committee Report:** *Tony Leone* distributed a revised position statement on the provision of heat in residential housing CARE contracts and reported that the PWA Caucus met 6/3/98 and reviewed the policy statements that were made at the Council's 5/26/98 meeting regarding heating in residential care funded facilities. They discussed and updated the HIV Consumer Rights Advocate position. The RFP for this position has been released. There was no bidder so the deadline has been extended again. They discussed the community input meetings. Those are going to happen next month. Tony urged Council members to participate. The teams include Housing, Youth, Women, and the Tenderloin. There was discussion of input at the CARE Council about Derek Silva Community. At the next meeting the Committee will work on grievance procedure policy language that could be used in a variety of agencies. *NN* asked how the original RFP was distributed; how potential bidders were notified that the RP had been extended; and what the cut-off date on the extension is. *TC* said the original RFP went out to a short list of about seven potential bidders. Three additional names were included after Council members reviewed the list. After the deadline he contacted the potential bidders and told them the new deadline is 7/10. *JC* mentioned that Veronika Cauley has volunteered to do a consumer input focus group in San Mateo Co. Anyone interested in assisting in this effort please contact Veronika. It was noted that this will be a first time effort for a focus group outside San Francisco. It was mentioned that Marin had county-wide meetings two weeks ago. It was asked if only non-profit agencies are eligible to apply for RFP. *TL* said the only restriction is that the provider not be someone who is already fundedto provide HIV/AIDS services because that would be a conflict. They want someone who specifically has advocacy experience and is familiar in dealing with HIV. *NN* noted that there is language in the CARE Act which restricts contracts to non-profits unless there is no non-profit that provides the service required. *DB* asked if there are any community input meetings targeting people of color. *TL* said none specifically, but they are planning to have meetings in geographical areas that would target those populations. They are going to try a variety of approaches. The people conducting each group will be responsible for determining these factors. A member asked how the focus groups will be publicized, and *TL* asked if they could do a press release. *TC* said they could. Someone asked if the timing is going to work, and *TC* suggested that people interested should go to the next Caucus meeting to address these issues. *WC* pointed out that with the demographics of this city there are three specific populations that should be targeted: Gay males, African Americans, and Latinos. It was suggested that Council members volunteer to work on this issue. *TC* said he was meeting with someone tomorrow to get technical assistance on how to proceed. *TL* said the community input meetings are going to happen before the next meeting of this Council. *LO* told the Council that after the vote at their 5/26/98 meeting people who voted yes on the motion concerning the use of unexpended 1997-98 funds received thank you letters from the mayor's office. Some members felt it was patronizing and divisive. *TL* pointed out that it was not the consensus of the Caucus that this was an issue.

B. Housing Committee Report

1. **Committee Report:**
2. **Introduction:** *Laura Thomas*, representing the Housing Committee, along with members of the Redevelopment Agency, the DPH, providers from the AIDS Foundation and Catholic Charities made a presentation at CHAS (Comprehensive Housing Affordablity Strategy) which is the city's primary housing planning group. The purpose was to inform the organization about the housing needs of people with HIV. One issue raised was the income level of people in need of housing. The perception was that most of them were middle income people. The actual housing wait-list indicates a very different population. *TC* urged people interested in housing issues to come to the next Committee meeting 7/1/98.
3. **San Francisco Redevelopment Agency:** *Olson Lee*, Housing Program Manager of the SF Redevelopment Agency, described the agency's efforts to update the HIV/AIDS Housing Plan. This is an attempt to give the DPH a road map for going forward. There are many issues that remain to be addressed and the agency will continue to evolve as they deliver services. HUD will provide new regulations and hopefully the housing market will get better in time. This has been an attempt to meet the needs of the people who need housing.
4. **SF AIDS Housing Plan Update:** *AlbertoLaos*, community member, read a poem that introduced the Housing Plan. *Carla Javits*, Program Director, Bay Area Office of the Corporation for Supportive Housing, distributed, and gave a summary of, the San Francisco Five-Year HIV/AIDS Housing Plan Update. In 1993 the DPH asked the Corporation for Supportive Housing and AIDS Housing of Washington to put together an AIDS housing plan. That document came out in 1994 and was planned to last for about 5 years. In 1998 the Redevelopment Agency asked for an update of the plan based on what's happening today. The planners met with about 100 people. There were: three general meetings; two meetings with rental assistance providers; a meeting with residential care facility providers; a housing focus group; and others. The context of the plan is hopeful. The real estate market is affecting housing significantly. There are 3,000 people on a wait list for housing, and 600 of them are homeless. In 1994 the first AIDS housing plan identified a shortage of beds for people with high levels of health care needs. Since then more than 100

beds have been added in this category. Consumer needs have changed since then. Fewer people are choosing licensed care facilities. Many need more help with mental health or substance abuse issues rather than physical health needs. Many who do need physical assistance need it only in the short term rather than long term care. Congress has been reducing funds for affordable housing. There has been flat funding for Section 8 programs. There have been modest annual increases to HOPWA funds but at the same time the jurisdictions that have been eligible for HOPWA money have gone up. Per capita HOPWA funds available to San Francisco in 1994 was nearly $1,500 per person. In 1998 that figure is $904. The rental housing market is tight. The Department of Housing and Urban Development (HUD) recently approved raising the Fair Market Rent (FMR) in San Francisco to 140%. The percentage of people with AIDS who are women, African American, and Latino have gone up while the percentages of those who are gay or bisexual have gone down. There is a summary of demographics on page 14, and a summary of homeless people on page 18. Inventory of available housing has doubled in the last five years. There are 2,475 beds now dedicated to people with AIDS. Most of the new beds are rent subsidies and emergency slots. In 1993 there were 58 rental subsidies, now there are over 1,000. Emerging needs have to do with mental health, substance abuse, and homelessness. There is more fluctuation in health now. FMR's are not always useful in the tight housing market. Many discrimination issues came up. Starting on page 50 there is a summary of all the recommendations. The highest demand is for rental assistance. In many cases it's needed to keep people in their homes. The Redevelopment Agency needs to try to: match population with appropriate housing; work with HUD to change regulations so recipients can pool subsidies to live in shared housing; and recognize and encourage landlords to participate in the rental subsidy program. There's a need to examine the impact of increasing the FMR's and the proposed use of CARE funds for short-term rather than long-term rental subsidy programs. There needs to be a "shallow" subsidy program to prevent evictions for those not currently receiving a housing subsidy. There should be an interim assistance program for people leaving treatment programs. There's a need for more capital investment. The wait-list needs clarification, people get frustrated trying to understand it. Many women are caring for extended families and need settings that are appropriate. The DPH should restructure its use of the Medi-Cal AIDS waiver to reimburse for services provided through licensed projects. DPH administered consumer surveys for people living with HIV/AIDS should include questions about housing status. Beginning on page 28 there is an effort to assess the question of rent subsidies versus capital redevelopment and how much of each is needed. *Carla* was asked if they had explored renting outside San Francisco. She said that there is a recommendation in the plan to take a look at that issue. *MJW* pointed out that mental health is often more of a problem than HIV now, and asked if a strategy for tapping into the housing funds available through Community Mental Health Services (CMHS) is addressed in this document. *Carla* said there is a recommendation (#11) which addresses that question. The interim programs could help with that issue as well. A centralized housing wait-list would help. She was asked if the Plan Update addresses owner move-ins and responded that it did not explicitly. It was suggested that it would be good to have a graph included in the Plan Update of the definition of income levels.

5. **HOPWA (Housing Opportunities for Persons With AIDS):** *Chris Harris*, Development Specialist of the SF Redevelopment Agency, gave a summary of what projects are being funded by HOPWA dollars. Funded through the Dept. of Housing and Urban development since 1990 HUD awards HOPWA funds annually, but unlike CARE funds it does not have to be spent annually. The San Francisco Redevelopment Agency is the administrator of the HOPWA funds which include San Francisco, San Mateo and Marin counties. San Francisco has received over $51,000,000. The Redevelopment Agency has funded four types of HOPWA developments: residential care facilities; permanent housing; transitional housing; and rental assistance. The AIDS Foundation currently oversees a centralized housing wait-list for people with AIDS. Most HOPWA projects assist people with AIDS who earn less than $24,000 annually. Five residential care facilities have been funded: Leland House in Visitation Valley; Peter Claver Community in the Western Addition; the Maitri hospice facility at Duboce and Church Streets; Richard Cohen facility on Dolores St. between the Mission and Castro districts; and the Larkin Street Youth Center at Hyde and Larkin Streets. Other independent permanent housing programs include: two programs operated by the Black Coalition on AIDS, Precita House facing Precita Park and Stinson House on Holly Park; the Hazel Betsy program located on 17th St. near Dolores Park; Page St. located in the Western Addition; Juan Cafari Plaza at South Van Ness and 21st St. in the Mission; and Planetree Housing Project in Bernal Heights. Transitional housing funded by HOPWA includes: Ferguson Place on Scott St. in the Western Addition; and A Women's Place on Howard St. HOPWA funds a rental assistance program serving over 300 households in a scattered site program. SF Housing Authority administers the program with Catholic Charities providing services. There are three pending projects: Rafiki House (which has been renambed the Brandy Moore House) on Turk St.; the Apollo Hotel on Valencia St.; and the Cecil Williams House on Ellis St. The biggest challenge is to evaluate the changes in the epidemic and determine what the needs of the client population will be. Another challenge is how to sustain what has already been created. Some facilities are extremely expensive to operate. The Redevelopment Agency just received an HUD award for Best Practices.

6. **Residential Care Facilities Evaluation:** *Louise Bourassa*, a consultant hired by the SF Redevelopment Agency, reported on her evaluation of five residential care facilities that are funded in part by HOPWA

funds including; the Assisted Care Facility run by Larkin St. Youth Services; Cohen Residence run by Dolores St. Community Services; Leland House run by Catholic Charities; Maitri which is a stand-alone agency; and Peter Claver Community also run by Catholic Charities. There are 155 pages of regulations that these licensed facilities must follow which are required by the Dept. of Social Services, yet there is no reimbursement by the State. These facilities serve populations with substance abuse, mental illness, dual diagnosis, triple diagnosis and dementia. Staffing patterns: total program staff ranged from .74 staff to 1 resident to 1.8 staff to 1 resident; direct care staff ranged from 1 staff to 3 patients to 1 staff to 16 patients; RN to client ratio is anywhere from 1 to 15 clients to 1 to 24 clients. Program costs tried to capture the total cost per resident a day at 100% occupancy, it does not include outside services that are provided but are separate from the program. The costs ranged from $113 a day to $ 304 a day. Maitri and Cohen Residence have higher administrative costs because those agencies contract for nursing care. Higher facility costs typically related to existing mortgages on facilities. Of 102 clients in these facilities only 14 received actual skilled nursing services from a home health agency and only seven received hospice care from a home health agency, and yet the needs for skilled nursing care remain high in these residences. There is still a need for hospice care. Medication management is becoming increasingly important. The average number of routine daily medications that were given to a client was 14. Many patient's medication regiments are so complex that they cannot manage their medications themselves. The average number of daily PNR (as needed) medications per patient was 5. System wide limitations to provision include: attendant care access; intake processes; transportation to appointments; inadequate training; difficulties in eviction; lack of affordable housing; and lack of vocational rehabilitation. Systemic recommendations include: restructure the Medi-Cal waiver program; develop a centralized pool of nursing attendants; establish a centralized training program; increase use of in-home support services; work with agencies to provide taxi vouchers; formalize relationship with Walden House; and establish funding for a part-time substance abuse and recovery support specialist. The main unresolved issue is how to support or reduce high operating costs of these facilities. Some possibilities include: collaborative training; attendant care pools; transportation; bulk purchasing; and evaluating baseline staffing ratios. They did not evaluate the appropriate number of licensed beds for the population. *TL* asked if the analysis of programs takes into account that more people want to live independently. *Louise* replied that the programs do try to tailor their plans to the individual, and many people do live very independently. *DJ* asked where Laguna Honda fits into the spectrum of facilities. *Louise* explained that Laguna Honda is not a residential care facility it's a skilled nursing facility. *DJ* pointed out that Laguna Honda is still the destination of many people leaving SF General Hospital, and asked if that is due to a lack of available beds in residential care facilities. *Louise* thought that was partly true, but also that the regulations governing residential care facilities do not allow for some of the services available at Laguna Honda that patients leavings a hospital setting may need. Someone asked if all these facilities were restricted to accepting clients from the housing wait-list. *DJ* responded that 10 beds at Leland House and all the beds at Maitri are not restricted to the wait-list but all others are. That's why Laguna Honda, St. Mary's and General hospitals are the primary destination of late stage patients.

7. **Department of Public Health Housing (including CARE):** *Mark Trot*, of the DPH Housing Unit, rounded out the financial picture speaking about money from the city's General Fund and CARE and distributed a breakdown of funding by program area. The DPH is in the process of consolidating its housing services into a single housing unit. There are 18 housing contracts, formerly handled out of the AIDS Office now being handled by the new housing unit. There are 3 main categories of housing services that the DPH funds: (1) Emergency Assistance which is one time cash assistance and emergency vouchers for short stays in residential hotels. (2) Supportive Housing which includes transitional and permanent housing. (3) Rental Subsidies which include; "standard subsidies" in which tenants pay 30% of their income toward rent and the remaining portion is covered by the program up to an established rent cap; and "shallow subsidies" that provide a lower level of subsidy and assistance to a greater number of people. In these programs tenants may pay up to 50% of their income toward rent. The DPH spends close to $7 million on housing, most of that being CARE funded and about $500,000 coming from the General Fund. The vast majority of the funding is in rent subsidies. Last year Emergency Assistance served close to 3,000 people, Supportive Housing provided 140 units of housing, and Rent Subsidies provided 600 slots. As the DPH continues to consolidate it will be consulting with the Council on ways to integrate funding and services to better serve their clients. The consolidation of subsidies that has happened this year is being handled by the AIDS Foundation who will disperse 326 subsidies. Changes in the Health Resources and Services Administration (HRSA) guidelines may not be as bad as formerly expected. It was pointed out that the figures for the Standard Rent Subsidies don't add up and that the General Fund Partial Subsidy Program is missing. *Mark* said they would check those items.

WC requested that item #11 on the agenda be moved up so the Council could vote while there was still a quorum.

11. **Discussion and VOTE:** *TC* announced a recommendation from the Housing Committee for funds that were not allocated this year during the prioritization process. They were part of the additional funds that came in above the worst case scenario. A decision was made later in the year to allocate 10% of that money to home health services. That amount came to about $96,000. The motion, as written, was to direct the AIDS Office

to use the unallocated funds in the home health subcategory to support the increased need for these services in those residential care facilities in need of support. *TC* proposed to the Council that they specify the services, and apply the funds to the third recommendation in the report that was given by Louise Bourassa. That recommendation was to develop a centralized pool of nursing attendants to be used by all the RCFCI's to augment staff when resident acuity is high or when the facility is in need of coverage. *TC* said this would be a good use of these funds. It gives the Council an opportunity to respond to a need that is being presented to it and it would be in keeping with the intent of the use of those dollars. The Council could reword the language to read "to direct the AIDS Office to use the unallocated funds in the home health sub category to develop a centralized pool of nursing attendants to be used by all the RCFCI's to augment staff when resident acuity is high or when the facility is in need of coverage." *NN* was concerned that this is essentially a new service that might trigger an RFP process. *TC* believes that the Council can do this without triggering the RFP process. *KB* asked to hear from the providers about the amount of funds needed to do this, whether the amount is enough and what the level of need is. The response was that this amount would only meet a portion of the need. *Chris Harris* said that HOPWA dollars might be used to pool with these funds in a matching amount. *WC* asked *TC* to restate the motion *TC* The motion is **"To direct the AIDS Office to use the unallocated funds in the home health subcategory to develop a centralized pool of nursing attendants to be used by all the RCFCI's to augment staff when resident acuity is high or when the facility is in need of coverage."** *BC* still wondered if an RFP may be needed. *TC* said that it's not. It was noted that it's important to spend the money rapidly. *JN* pointed out that many of the recommendations emphasize skilled nursing care and the other recommendations emphasize collaboration which includes mental health and substance abuse that can be done with other agencies. This is the only recommendation that would need money right now. The motion was seconded, voted on and passed [2].

WC suggested moving item #9, the Home Health presentation, up on the agenda.

9. **Home Health:** *Russ Zeller*, of the DPH, provided data on in-home health services. In 1996-97 about 93% of the dollars were spent, and 92% of the units of service were provided. In 1997-98 about 96% of the dollars were spent, 93% of the units of service were provided, and 84% of unduplicated clients were served. General Funds for Visiting Nurses and Hospice intermittent home care spent 97% of their funds, provided 97% of their units, and went way over on their unduplicated client count with 214%. AIDS Hospice Care spent only 66% of their funds, provided 60% of their units, and served 65% of their clients.

Kathy Eng, Administrator within the DPH for Health at Home, distributed funding information. Their funds come from the General Fund with two contracts totaling $613,133. The number of clients transferred to them from VNH were 21. The number of HIV/AIDS clients currently being served is 47 which accounts for about 25% of their total case load. The number of unduplicated HIV/AIDS clients served in 1997-98 was 89. The number of HIV/AIDS client admissions in 1997-98 was 99. The number of HIV/AIDS visits 1997-98 to date is 2,242. The projected number of HIV/AIDS visits for 1997-98 is 2,492. The percentage of projected HIV/AIDS visits delivered to date is 90%. Health at Home started as a small pilot project. This year they expect to be up to 12-14,000 visits by the end of the year and next year they anticipate 18-20,000 visits. *WC* asked what the relationship is between the number of HIV/AIDS clients served in 1997 and the number of visits. *Kathy* said that the client number refers to the people who apply for service, the number of visits is cumulative. *Sharron Miller* asked how many of them are AIDS intermittent clients versus people who are on intermittent skilled plan care, and if there is any differentiation *Kathy* said that there is no differentiation. The majority of visits are covered by General Fund dollars. Only about 15% are reimbursed by Medi-Cal. and less than 10% are reimbursed by Medi-Care. *LO'C* asked what accounts for the projected number of clients rising and yet fewer people needing skilled care. *Kathy* said the original estimates that were given for this service were about 70% lower than they should have been which accounts for why the number of visits has risen so dramatically. She was not sure why the need has increased but it has for the Community Health Network (CHN) of the DPH. She thought perhaps the continuity of care has appealed to both the clients and providers. MJW pointed out that just because the service provided by this unit has increased does not mean that the need has increased. The numbers may be increasing because it's a brand new unit and they are building capacity.

Sharron Miller, Director of Hospice and Community Service Programs, at Visiting Nurses and Hospice of San Francisco, distributed a chart describing where their CARE and General Fund dollars go. VNH receives CARE funding in the following categories: Housing; Residential Hospice; In-Home Respite; and Home Health Care. Their General Fund contract transferred to Health at Home last October. Their CARE contract expired in March of this year and they just got the new awards letter last week for the current fiscal year. It's hard to know what their projected units of service are going to be. Confusion in the community regarding the status of the agency has affected referrals to it. The In-Home Respite service has not met its units of service over the last several years. Reasons for this may be: (1) When the contract for VNH was originally written there were not 114 residential care beds in the community, many people were being cared for at home. Now more patients go into residential care. (2) Some patients who use VNH are long term users so there is little turnover. (3) The transition of CARE dollars to Health at Home has affected the

referral process, there is less collaboration and coordination. The Home Infusion contract is also being used less. Fewer patients are being maintained for a long time on infusion therapy. Residential Site Care provides staffing for the AIDS patients who live at Coming Home Hospice, the Maitri facility and at Cohen House. The new Maitri facility is staffed with LVN's as well as health care aids and at a higher level than the old Maitri facility was. The Cohen facility is a new contract for VNH as of last year. There are challenges to meet the units of service needed under these three contracts at the current funding level. For example, under Residential Site Care the roll-over contract was for 1,187 days that were allowed for in the contract and VNH actually provided 1,900 units. That's a lot of funding that the VNH has to provide. *DJ* asked if the numbers for Residential Site Care reflect all categories of service in the amount VNH anticipates being over utilized for the year. *Sharron* thought that in most cases the answer was yes. The exhibits that will probably be under utilized are In-Home Respite and Home Infusion. She was asked if Attendant Care would be under budgeted. She thinks those dollars will be used. Someone asked if VNH care included care at home for HIV children. *Sharron* said that's never been targeted as a category. *MJW* asked if the Council should be looking at redistributing Attendant Care funds so that VHN has more realistic units of service and more realistic funding for their exhibits. *Sharron* said that's what they hoped to do with the renegotiation of their contract with the AIDS Office. VHN would like to split the funding up based on how the epidemic has changed. She still thinks there may be a shortage of funds. One estimation showed a $400,000 shortfall. *WC* asked her to predict, based on last year's projections and going into this year's prioritization, what the Council should be looking at. *Sharron* said addressing issues of patients in the residential care facilities is a high priority. These are almost skilled nursing level facilities yet they are not eligible for reimbursement. There is a fine line between offering these desirable services while giving up the reimbursement that the system currently pays to care for those people, and using CARE dollars to duplicate that in a level of care that doesn't have a line of reimbursement. *TC* asked what the status of the Residential Hotel contract is. *Sharron* said that is one contract that VHN wants to renegotiate with the AIDS Office. They formerly had their office at the Ambassador Hotel but since they were advised that their contract was ending in February they canceled their contract with the Ambassador. They still have a nurse, a social worker and a home health aide working in the Tenderloin. Some of their former patients have now gone into the Bridges Project with whom VHN works closely and they hope to use some of their funds to expand that collaboration. Sharron was asked if there are ways that the Medi-Cal AIDS waiver could be reconfigured to leverage additional dollars to pay for some of these services. She said she had looked into the possibility of opening a Medi-Cal waiver office in San Francisco but was told that the state did not have the staffing to do that. It was pointed out that people are not dying from AIDS as much as they are dying from the side effects from the drugs they're taking. *Sharron* thinks part of the solution is the utilization of the AIDS waiver case management dollars to have nurses do case management with those patients.

WC suggested a postponement of agenda item #8. Housing - Discussion.
LT asked that interested people come to the next Housing Committee meeting on 7/1/98 from 10 AM to 12 PM at the AIDS Office 5th floor conference room.

X. **New Business:** None

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XI. **Adjournment:** 8:30 PM

The Council meets on the third and fourth Mondays of each month, at the time and place noted above. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For HIV-Positive members requesting excused absences due to illness, contact Tom Calvanese at 621-7712. *Minutes of meetings are tentative until formally approved by the Council.*

P=Present; **A**=Absent; **E**=Excused;

	[1]	[2]
James Abrams	A	
Kirsten Balano	P	Y
Marianna Balquiedra	A	
Dorothy Bartolomucci	A	
Donald Bliss	P	Y
Jeff Byers	P	Y
Virginia Cafaro	A	
Tom Calvanese	P	Y
William Carter	P	Y
Bart Casimir	P	Y
Veronika Cauley	A	
Fernando Chavez	P	Y

L=Leave of Absence;

	[1]	[2]
Michael Chesek	P	Y
John Conley	P	Y
Mark Dunlop	P	Y
Mariam Farooq	E	
Gene Gowdey	A	
Diane Jones	P	Y
Susan Karp	A	
Tony Leone	P	Y
Steve Lew	E	
Allen Meyer	P	Y
Lee Ann Monfredini	A	
Norm Nickens	P	Y

Y=Yes; **N**=No; **B**=Abstain

	[1]	[2]
Johnnie Norway	P	Y
Lisa O'Connor	P	Y
Loras Ojeda	P	Y
Stephen Oxendine	A	
Alissa Riker	P	Y
Nilda Rodriquez	P	Y
Matthew Sharp	P	Y
Thomas Sinclair	E	
Laura Thomas	P	Y
Brett VanBenschoten	P	
Kelly Wallace	A	
Mary Jane Wood	P	Y

Michael

HIV HEALTH SERVICES PLANNING COUNCIL

July 20, 1998 4:30 - 7:30 PM

25 Van Ness, 3rd Floor Conference Room

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Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	
III.	Review and Approval of Minutes from meeting of 4/27, 5/26	4:35 PM
IV.	General Announcements	
V.	Public Comment	4:45 PM
VI.	PRIORITIZATION	5:00 PM
	A. Council Representation/Areas of Expertise & Conflict of Interest Information	
	B. Evaluation Committee: Utilization Data Presentation - Ali Riker	
	BREAK	6:00 PM
	C. Planning Committee: Primary Care Presentation/Discussion	6:15 PM
VII.	Consumer Rights Advocacy Program -	
VIII.	Recommendation from Review Panel - VOTE	7:15 PM
IX.	New Business	7:30 PM
X.	Adjourn	7:35 PM

Future Meetings:

July 27, 1998 - Planning Council, 25 Van Ness, 3rd Floor Conference Room, 4:30 PM - 7:30 PM
August 3, 1998 -Housing Services - location to be announced, 4:30 PM - 7:30 PM
August 4, 1998 - Health Care Services - location to be announced, 4:30 PM - 7:30 PM
August 5, 1998 - Mental Health Services - location to be announced, 4:30 PM - 7:30 PM
August 5, 1998 - PWA Caucus - 25 Van Ness, 3rd Floor Conference Room, 5:00 PM - 7:00 PM
August 6, 1998 - Substance Abuse Services - location to be announced, 4:30 PM - 7:30 PM
August 7, 1998 - Other Support Services, Marin & San Mateo - location tba, 4:30 PM - 7:30 PM
August 7, 1998 - Membership Committee - 25 Van Ness, 5th Floor Training Room, 9 AM - 11 AM
August 10, 1998 - Steering Committee, location to be announced, 5 PM - 8 PM
August 17, 1998 - Planning Council, location to be announced, 4:30 PM - 7:30 PM
August 24, 1998 - Planning Council, location to be announced, 4:30 PM - 7:30 PM
August 31, 1998 - Planning Council, location to be announced, 4:30 PM - 7:30 PM
(MEETINGS IN BOLD ARE PRIORITIZATION MEETINGS)

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I. **Call to order:** 4:45 PM.

II. **Roll Call** [1]

III. **Review and Approval of the Minutes of 4/27/98 and 5/26/98.** *KB* requested an addition under General Announcements of the 4/27 minutes to state that the Council passed the motion "based on the timeline." *BVB* corrected the roll calls noting that he had a leave of absence for the months of May and June.

IV. **General Announcements:**

A. *KB*alano passed out a draft flyer for the Community Forum for Women Living with HIV, sponsored by Lyon Martin Women's Services, to be held on Monday, Aug. e, 7 PM, at 1748 Market St.

B. *MS* announced his new job as Treatment Education Certification Progarm coordinator and trainer at the Asian & Pacific Islander Wellness Center.

C. *BC* announced the upcoming National Association of People with AIDS conference at the Hyatt Regency Hotel in San Francisco.

D. Wayne Sauseda is leaving his position at the California State Office of AIDS in August.

E. Belmont House located in San Mateo has closed. Its' residents have been transferred to other facilities.

F. *MB* alerted Council members that there is a bill in the U.S. Senate which, if passed, will reduce housing funds.

G. *JN* will be resigning from the Council in September.

H. *BVB* said that Chris Boehm was nominated by the principal investigator for Title IV to be a represenative on the Planning Council.

I. *TC* distributed several handouts including: 1) A prioritiaztion schedule for the fiscal year '99-'00 that lists, besides the usual monthly meetings, focus group meetings to be held the first week of August to prioritize recommendations for funding. 2) A schedule of community forums and sign-up sheets for them. 3) Copies of the 1998-99 HIV Health Services Planning Council Membership Nomination Form.

J. Additional handouts included: 1) An urgent alert to contact the U.S. Senate Appropriations Subcommittee and ask them to support an increase of Title I and Title III funding. 2) A notice from the Office of the Mayor announcing four community forums for collecting citizen input that will be used in decisions regarding 1999 programs funded through the Community Development Block Grant, the Emergency Shelter Grant and the Home Investment Partnership Grant (HOME). 3) A report to the community, on the 12th World AIDS Conference, in Geneva, to be held July 22, from 1-5 PM, in Cole Hall, 513 Parnassus, on the UCSF Campus.

V. **Public Comment:**

Vida Y Movimiento, a gay Latino community group, contested the funding cut of their program by the AIDS Foundation. They distributed a letter, and a notice of a public forum to discuss the elimination of the program to be held Wednesday, July 29, at Brava Theater Center on 24th St. at 6:30 PM.

George Simmons delivered a memo from Howard Rogers, Dir. of HIV and Clinical Services at Catholic Charities regarding the Derek Silva Community.

Susan Buchbinder, MD, Dir. of Research at the AIDS Foundation, spoke about the reallocation of funds with more emphasis on women and housing.

VI. **Prioritization**

A. Council Representation/Areas of Expertise and Conflict of Interest Information.

Laura Thomas (who has a new job in the AIDS Office and can be reached at 554-9169) is working on the Title I Grant Proposal and will mail a copy to anyone who wants one. She told the Council that it's important the proposals reflect the community living with HIV. She noted that Latinos are significantly underrepresented on the Council. The demographic information form needs to be returned to her ASAP.

TC passed out an organizational affiliation disclosure form that he requested Council members return to him by next week. The form will help the Council determine member's areas of expertise and/or conflict of interest information. *MS* asked if past affiliations should be included. *TC* suggested going back three years.

B. Evaluation Committee: Utilization Data Presentation - Ali Riker.

AR introduced *Russ Zellers*, Asst. Chief of Health Services at the AIDS Office, who distributed and explained two spread sheets. One summarized Fiscal Year 97-98 Utilization by Service Sub-Category which noted the rationale for low expenditures or deliverables. The second spread sheet summarized the Units of Service (UOS) utilization for fiscal year 96-97. Some numerical discrepancies were noted by Council members. *Russ* said he would check the figures and get back to the Council next week. *AR* passed out a recommendation regarding utilization data that suggested funding cuts be taken proportionally across all categories. The rationale for this position was that, due to the past changes made in the service system, it would not be appropriate to use utilization data from 97-98 before the implementation of these changes. *KB* pointed out that this information is based on utilization at the contract level and that the data which the AIDS Office will present next week on utilization(URS) and barriers to service will reflect utilization at the service level. *LO* asked what constitutes under utilization of service as stated on the spread sheet. *TC* said that might not be the

right term to use. *DJ* pointed out that, in some cases, what appears to be under utilization of service may be staffing problems. She also said that discussions have been had as to where this money will go. *Russ Zellers* said that the funds add up to the amount requested from the Health Resources and Services Administration (HERSA). *BC* pointed out that the Council does not have all the information it needs about how funds were spent last year, to prioritize current funding recommendations on time. *LT* said that this is part of a multi-year plan so the Council should not just look at last year's information for priority setting. *WC* noted that it may be harder for the Council to determine how to move forward this year since last year they were involved in details that will not apply this year. *TC* said that was the reason the Evaluation Committee made the recommendation it did. *DJ* made several points: 1) The Department of Public Housing (DPH) has difficulty moving people into positions which gives the appearance that funds are not needed in certain areas. 2) Where can housing subsidies be moved faster? 3) This year's analysis of utilization data is more qualitative than last year's. *JB* voiced concern about the recommendation. *MJW* pointed out that the recommendation relates only to utilization data. *AM* asked what the change in definition of primary care was between 96-97 and 97-98. *Russ* said there must have been a change in the definition of a UOS. *LO'C* noted that people frequently leave substance abuse programs so funds do not get spent. *MS* suggested that while the Council needs to focus on qualitative data, they also need to be ready to explain to the community how decisions were made. *KB* thought that the figures in the Variance column of the 97-98 spread sheet did not seem accurate. *Russ* said that those figures were correct but that the Total Paid column needs to be recalculated.

C. Planning Committee: Primary Care Presentation/Discussion.

1). *DJ* summarized the four factors that are affecting primary care of people with HIV: 1) There is a growing impact of HIV on a wide diversity of populations. 2) Emerging therapies need to be made available to all populations with HIV. 3) The changes in financing primary care affect the level and consistency of care some people get. 4) Documentation of funds is important because it impacts future funding.

2). *KB* reported on the Geneva conference for Steve Deeks who was unable to attend the Council meeting. There is good news with the combination therapies but the complicated dosing schedule makes adherence difficult. There is an effort to decrease the complexity of the regiments. Not everyone responds to these therapies. There are three or four emerging therapies that will be available by the end of this year. *MS* noted that these new drugs will not be available on AIDS Drug Assistance Program (ADAP) for a while after they are released. *KB* mentioned that there are innovative programs being developed to help people adhere to their regiments. Contra Costa County has an adherence program while San Francisco does not. *MS* said some practitioners have adjusted their dosing to twice daily rather than three times a day. *WC* informed the Council that summaries of the Geneva conference are available on the internet. *KB* wrapped up by saying that accessibility to therapy is a critical issue worldwide.

3). *Dr. David Bangsberg*, Director of the EPI Center, SF General Hospital, made a presentation about his work in the Tenderloin with HIV clients. He first noted there was more pessimism at the Geneva conference than at other conferences in the recent past. Therapies are available to very few people, even in S.F., but once a day therapy is not far away. There are 1,500 homeless HIV positive people in San Francisco and 72% of them are not on any therapy. Access to care is not a barrier in San Francisco. Providers are concerned that adherence to a therapy will not be maintained, yet research has found that adherence to regiments is 80% in the homeless population, better than expected. It's the same percentage as the general combination therapy population in San Francisco. This is still not good enough, most providers believe there needs to be 90% adherence to a regiment for it to be effective. Three residential hotel fires in the city in the last year which has depleted the number of available rooms for people who live as single room occupants (SROs).

4). *Guy Vandenberg*, Director of External Programs, Continuum HIV Day Services, works with the Tenderloin Care Project that provides integrated services for a population of largely hotel and SRO dwellers. They have found that clean water is the most popular item among the homeless when they hand out food packs. They are now able to test people for HIV. Prescription negotiation between doctor and client seems to be a successful arrangement. One of the problems health care providers face is that, to access CARE funds, clients need a letter of diagnosis to be treated and they cannot get a letter without an address. *LT* said that outreach to get people into CARE is available under Ryan White but the Council needs to prioritize it as a service which has not been done yet. The Council cannot fund prevention outreach. She then asked how much of this population was on to protease inhibitors because they had already become resistant to them. *Dr. Bangsberg* responded that 40% of their clients have not been on any combination therapy when they are interviewed. *Guy* pointed out that in prison populations only a small percentage are tested and treated for HIV and when they are released from prison they are given a ten day supply of medication. Many of them cannot arrange to continue their medications within that time. Many clients also have severe liver damage that does not make combination therapy a good option. *TC* stated that what was being said bore out the Councils suspicions that having access to services does not mean people are getting them. A Council member pointed out that some people are in the process of getting onto a therapy that may take six months to a year. *Dr. Bangsberg* agreed that there is access since three-fourths of their clients are already seeing a doctor but only 26% of those clients are on combination therapy. A very important question for doctors is determining when the right time to start a patient on therapy is. TC said the figures need to be followed carefully to determine if clients are being evaluated properly. *DJ* said there is a chasm between who's on the "gold standard" and who's not when race, gender, and drug use are factored in. Many people who come

into S.F. General Hospital for treatment know about combination therapy but reject it. *TC* noted that the discussion emphasized the importance of including adherence when talking about access. He also said that outreach needs to be incorporated into all the CARE contracts. *Michelle Dixon*, Dir. of Health Services, AIDS Office, pointed out that although outreach may not be stated in a contract it is often included in the service provided. *JN* asked, in regards to youth, how much outreach the HIV Prevention Planning Council (HPPC) does, how much CARE does and who does the testing. He pointed out that testing and prevention are the most useful tools in reaching youth. *DJ* said the number one requested service is HIV testing. Someone asked if there is a protocol for the people who do not have a provider. *Dr.Bangsberg* said that they are referred to either the Tom Waddel Clinic or St. Anthony's Clinic for an appointment within 24 hours, and they have a 90% completion rate on that referral. *AM* noted that integrated services become increasingly important when trying to get people on combination therapies. *Dr. Bangsberg* responded that there is money from the Mayor's Office to create "action sites" where patients can get a variety of services and their provider can be kept informed of their progress. Someone asked what percentage of clients who are not on therapy have CD4 counts over 500. *Dr. Bangsberg* said that CD4 numbers are not a factor in getting treatment. *Guy Vandenberg* said that a San Quentin people who have CD4 counts over 500 do not receive viral load tests. *SL* wondered how may clients are getting integrated services. *Dr. Bangsberg* said that they are now referring all their clients to integrated services. *WC* noted that more prevention services are needed to work with the CARE services.

VII. **Consumer Rights Advocacy Program**

Tony Leone gave background on the subject. The PWA Caucus developed the idea of having ombuds services available for people with HIV/AIDS. The Council approved the idea and an RFP was sent out. A proposal was received. A review panel met and made recommendations that will be presented to the Council today.
Tom Calvanese named the panel members: *Tony Leone* and *Nilda Rodriguez* (co-chairs of the PWA Caucus), *Tom Calvanese, Mark Dunlop Loras Ojeda* and *Matthew Sharp*. They received one proposal. It was scored in four areas: 1) experience and past performance, 2) scope of work, 3) program structure, and 4) budget. Out of a possible score of 100, the average score of the reviewers was 73. The recommendation to the Council is that they fund this project. A detailed technical review document is in the process of being compiled for Council members and will be available at next week's Council meeting. If the Council approves the recommendation they would then negotiate with the provider to enter into a subcontract with the Planning Council Support Center that would alleviate going through the entire contracting process. Toni Young submitted the proposal under the National Women in AIDS/HIV Project. Five major points raised during the review process were: 1) salary level, 2) HIV status of employees, 3) accountability evaluation since this program will be accountable to the Council rather than the AIDS Office, 4) fiscal responsibility oversight, and 5) focus on resolution of problems, at the earliest possible point of intervention. Tom was asked of Toni Young currently works for Catholic Charities and if that creates a conflict. *TC* said that she would have to leave her current position if she receives this contract. It was mentioned that she was also a co-chair of the HPPC and docs that create a conflict. *TC* thinks not, based on the RFP requirements. It was pointed out that the focus of this contract needs to be customer service. *TC* said that had been a primary factor when the panel was discussing the proposal and that there would be quarterly reviews to evaluate the program. WC asked the panel if they had any concerns. *TL* thinks the program will grow and evolve, but it has a good foundation to start with. *MJW* wants to make sure the Council is not being naive about doing their own contract for the first time. Once the contract is signed for a specific amount of time the Council will have to live with it, so make sure the Council gets what they want out of the contract. *SL* asked what the strengths of the proposed program were. *TC* said he was intending to make a more detailed report next week but that the proposal captured the spirit of what the Council was looking for. The individual has extensive experience with HIV/AIDS as well as experience in advocacy. There were clearly outlined objectives stated. The description of the problem was clear. The proposal included peer advocacy as part of its' goal. It stated how information would be brought to the Council through the PWA Caucus on a regular basis that is currently missing.

VIII. **Recommendation from Review Panel - VOTE**

A roll-call vote on the PWA Caucus panel recommendation to approve the proposal for a Consumer Rights Advocacy Program was held. The proposal passed. [2]

IX. **New Business:** None

X. **Adjournment:** 7:45 PM

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P=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence; **Y**=Yes; **N**=No; **B**=Abstain

	[1]	[2]
James Abrams	A	
Kirsten Balano	P	Y
Marianna Balquiedra	P	Y
Dorothy Bartolomucci	P	Y
Donald Bliss	P	A
Jeff Byers	P	A
Virginia Cafaro	A	
Tom Calvanese	P	Y
William Carter	P	Y
Bart Casimir	P	Y
Veronika Cauley	P	Y
Fernando Chavez	A	
Michael Chesek	A	
John Conley	P	Y
Mark Dunlop	P	Y
Mariam Farooq	A	
Gene Gowdey	P	A
Diane Jones	P	Y
Susan Karp	A	
Tony Leone	P	Y
Steve Lew	P	A
Allen Meyer	P	A
Lee Ann Monfredini	A	
Norm Nickens	P	A
Johnnie Norway	P	Y
Lisa O'Connor	P	Y
Loras Ojeda	P	Y
Stephen Oxendine	A	
Alissa Riker	P	Y
Nilda Rodriquez	P	Y
Matthew Sharp	P	Y
Thomas Sinclair	E	
Laura Thomas	P	Y
Brett VanBenschoten	P	
Kelly Wallace	P	
Mary Jane Wood	P	Y

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HIV HEALTH SERVICES PLANNING COUNCIL

July 27, 1998 4:30 - 7:30 PM

AIDS Office, 25 Van Ness, 3rd Floor Conference Room

AGENDA

I.	Call to Order		4:30 PM
II.	Roll Call		
III.	Review and Approval of Minutes from meeting of 6/15 & 6/22		
IV.	General Announcements		4:35 PM
V.	Public Comment		4:40 PM
VI.	Staff Report		4:50 PM
VII.	PRIORITIZATION		5:00 PM
	A.	Epidemiological & Seroprevalence Data - DPH	
	B.	URS Utilization Data & Barriers to Service	
		BREAK	6:00 PM
	C.	San Mateo & Marin Counties – demographics & Epidemiology Update	6:15 PM
VIII.	Housing Plan Endorsement - VOTE		6:45 PM
IX.	Membership Committee Report		7:00 PM
X.	New Business		7:15 PM
XI.	Adjournment		7:30 PM

Future Meetings: (MEETINGS IN BOLD ARE PRIORITIZATION MEETINGS)

July 27, 1998 - Planning Council, AIDS Office, 3rd Floor Conference Room, 4:30 PM - 7:30 PM
August 3, 1998 -Housing Services - AIDS Office, 3rd Floor Conference Room-A, 4:30 PM - 7:30 PM
August 4, 1998 - Health Care Services - AIDS Office, 3rd Floor Conference Room-A, 4:30 PM - 7:30 PM
August 5, 1998 - Mental Health Services - AIDS Office, 3rd Floor Conference Room-B, 4:30 PM - 7:30 PM
August 5, 1998 - PWA Caucus - AIDS Office, 3rd Floor Conference Room-A, 5:00 PM - 7:00 PM
August 6, 1998 - Substance Abuse Services - AIDS Office, 3rd Floor Conference Room-B, 4:30 PM - 7:30 PM
August 7, 1998 - Other Support Services,
Marin & San Mateo - AIDS Office, 3rd Floor Conference Room-A, 4:30 PM - 7:30 PM
August 7, 1998 - Membership Committee - AIDS Office, 5th Floor Training Room-A, 9 AM - 11 AM
August 10, 1998 - Steering Committee, AIDS Office, 5th Floor Conference Room, 5 PM - 8 PM
August 17, 1998 - Planning Council, AIDS Office, 3rd Floor Conference Room-A, 4:30 PM - 7:30 PM
August 24, 1998 - Planning Council, AIDS Office, 3rd Floor Conference Room-A, 4:30 PM - 7:30 PM
August 31, 1998 - Planning Council, AIDS Office, 3rd Floor Conference Room-A, 4:30 PM - 7:30 PM

NOTE: SCHEDULE OF COMMUNITY FORUMS WILL BE DISTRIBUTED SEPARATELY

San Francisco Department of Public Health – AIDS Office, 25 Van Ness:

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I. **Call to order**: 4:45 PM.

II. **Roll Call** [1]

III. **Review and Approval of the Minutes of 6/15/98 and 6/22/98.** Corrections to the 6/15 minutes: *BVB* said that on page 3, in the third paragraph the organization's name is Bay Area Young Positives. *DB* was present at the meeting. The minutes were approved with corrections, *AM* abstained. The minutes to the 6/22 minutes were approved with no corrections, *JB* abstained.

IV. **General Announcements:**

A. *Diane Jones* informed the Council that Tom Calvanese had an accident while riding his bicycle and was at Kaiser Hospital.

B. *Brett Van Benschoten* distributed two flyers announcing upcoming discussion groups for Reality magazine about youth, HIV, drug use, and recovery. The meetings will be Tuesday, Aug. 4th, and Wednesday, Aug. 5th, from 6:30 to 7:30 PM.

C. *William Carter* informed the Council of the results of the Latino/a Community Forum. There was discussion of the cut funding for *Vida Y Movimiento* and an announcement of a public forum to discuss the elimination of the program to be held Wednesday, July 29, at Brava Theater Center on 24th St. at 6:30 PM. He also pointed out that there is a feature article in the current POZ magazine interviewing Brett Van Benschoten.

D. *Kirsten Balano* mentioned that Abbott Labs is having problems supplying the capsule formulation of Norvir. The liquid formulation is available until they work out the problems with the capsule. Current supplies of the capsule are safe.

E. *Lisa O'Connor* distributed flyers for upcoming Community Forum meetings.

F. *Loras Ojeda* commented that the Latino/a Community Forum had a good turnout of about 25-30 people and it was a useful discussion.

G. *Veronika Cauley* announced that members of the Veteran's Administration will address HIV in the Veteran's community at the Council's Aug. 4 - Health Care Services meeting.

V. **Public Comment:** A number of organizations that work collaboratively appeared before the Council to request sustained funding for their programs which focus on support for women and children with HIV. They included: 1) Nan O'Connor - Center for Special Problems. 2) Linda Hammond - Circle Counseling Center for Women and Children. 3) Mary Pantlow - S.F. AIDS Foundation Women's Program. 4) Orgelina Wiese - Family Support Services of the Bay Area Programs. 5) Dorothy Goldstone - Mothers Organizing Mothers (MOMS). 6) Julie Charubusapayon - UCSF Women's and Children's Clinic.

VI. **Staff Report**

A. *DJ* introduced *Tony Young* who has filled the new Consumer Rights Advocate position. *Tony* said she hoped she could work in partnership with the Council to fill gaps in service to the public. *LO* said that the review panel wanted to discuss their recommendation of Tony Young in detail at this meeting but since Tom Calvanese was not present they felt that discussion should be put off until he could be part of it. *WC* was glad that Tony had applied for the position and said this is an example of how the Council responds to community requests and tries to find resolutions to problems as they arise.

B. *DJ* introduced *Sauda Burch* from Interaction Associates who will help facilitate the August meetings.

C. *DJ* passed out several documents related to the 1999-2000 prioritization process: 1) An overview/consensus. 2) Criteria defining severe need. 3) The August '98 meeting schedule. 4) Guidelines for Prioritization Task Forces and a sign-up sheet for upcoming Task Force meetings. *WC* stressed the importance of all Council members attending some of the prioritization meetings. These meetings replace the retreat that has happened in the past to determine priorities. *DJ* pointed out that the location and meeting times of the prioritization meetings are listed on the bottom of today's agenda.

D. *Laura Thomas* needs demographic information forms that were sent out with the last minutes.

E. *DJ* distributed revised Utilization Data from *Russ Zellers* in the AIDS Office and reminded Council members to bring this document with them to the prioritization meetings in August.

VII **Prioritization**

A. Epidemiological & Seroprevalence Data - Department of Public Health (DPH).
Sandy Schwarcz, C-Chief of Surveilance at the AIDS Office, presented data on reported cases of AIDS in San Francisco as of June '98.

- Total number of people living with AIDS is about 8,000.
- Health insurance coverage is 40% private, 23% none, 23% unknown, and 14% Medi-Cal.
  Women make up a greater proportion of underinsured (the term underinsured includes Medi-Cal, public insurance, and no insurance).
  People of color make up a larger percentage of the underinsured population.

By risk factors; intravenous drug users (IDUs) and men having sex with men intravenous drug users (MSM-IDUs) are the highest underinsured groups.
By age the highest underinsured group (17%) is under 30.

MJW pointed out that the under-insured could include people who have private insurance but the service being provided is not covered by their insurance and that might change the statistics.
Sandy was asked if there was a breakdown of data to indicate survival rates by ethnicity or gender. She said that women have a higher survival rate and that there was no difference by race. Some members disputed that statement and *Sandy* explained that often statistics were national figures and that the picture in San Francisco is very different. *JN* asked if the Council will be getting the survival analysis. *Sandy* said it would.

- Use of protease inhibitors.
  36% of men and 29% of women are using them.
  There is lower use by African Americans and Native Americans.
  By age group; the youngest and oldest groups are less likely to use them.
  By insurance group; private has the highest rate of coverage.

SL asked how accurate the data was since it is based only on reported cases. *Sandy* said their information was quite accurate. They have a number of tools to assure accuracy of reporting. *JC* pointed out that there are a large number of people currently using services that are not diagnosed with AIDS but are HIV positive that are not included in these statistics. Using AIDS based data only is making it harder each year to predict the trends of need within the HIV/AIDS community. *WC* noted the frustration in trying to prioritize with this information. The Council needs to work with the AIDS Office to develop the tools needed to make their data more useful to the Council. *Laura Thomas* said that the data seen in this presentation accurately covers about half of the HIV population in San Francisco.

Willi McFarland, MD, S.F. DPH, spoke on the status and direction of the HIV epidemic in San Francisco, based on the 1997 Consensus meeting and recent data.

- Over 15,000 people were living with HIV in 1997.
- MSM is by far the largest risk population.
- Whites account for the majority of HIV cases. Infecting rate is decreasing, but more slowly for minorities.
- AIDS cases peaked for both men and women in 1992.
- The relative burden of AIDS may be shifting because cases are not falling as fast for some ethnic groups compared to Whites. This is in contrast to the rest of the country, where cases are increasing among non-whites, especially African Americans and Latinos.
- AIDS cases are also falling for all risk populations. This is also in contrast to the rest of the country, where AIDS cases are increasing among heterosexual women.
- The vast majority of HIV transmission occurs from ages 25-35.
- A model projecting figures from 1975 to 2025 suggests an end to the epidemic but also suggests that AIDS may become "endemic" in San Francisco which means that new HIV infection equal new AIDS cases yearly. The toll is 500 San Franciscan lives a year.
- HIV prevalence at the STD Clinic is 8 to 9%; among young gay men, again around 8% of gay men under 22; among clients of a methadone clinic around 10%. Similar figures were seen at a detox clinic.
- Family planning clinics saw low levels of infection among women and no evidence of increase. The same levels were seen in a survey of infants born in S.F.

Limitations:

- Lack of data for some marginalized populations.
- Bias, undercounting, apparent inconsistencies in data for some populations
- Missed epidemics, masked epidemics, foci of transmission
- Numbers do not indicate unmet needs in themselves.

Conclusions:

- San Francisco is different.
- Endemic state: 500 new HIV cases each year - 500 new AIDS diagnoses each year.
- New infections likely to occur among same groups (risk, race, age, gender) in same pattern as seen in past
- ...unless radical changes in risk (better or worse), prevention methods and efforts (enhanced or relaxed), treatments (cure or survival).

Recommendations:

- Maintain a high level of vigilance for HIV, especially in marginalized populations.
- Do not accept endemic state, work towards eradication.
- Look for new paradigms in HIV prevention.
- Focus on: 1) recent HIV infections. 2) Viral load suppression. 3) Reduction of transmission to others. 4) Partner notification. 5) Network notification.

VC pointed out that there were no statistics in any of this data relating to the transgender population in San Francisco. *Willi* said that Kristin Clement has done a survey of the transgender community and that the

Council should review it because the highest rate of HIV transmission in San Francisco is in this group. *SO* asked why San Francisco is different. *Willi* said that the city started working on the epidemic earlier than anywhere else and found that the prevention process worked. *WC* asked where the ideas for partner and network notification recommendations came from. *Willi* said, for example, improved HIV treatment, modification of HIV testing (the detuned ELISA) which allows detection of infection in the last six months, and lower case loads make partner notification more acceptable and more effective. *LO'C* said it's hard to hear that there is no difference in the data for women when experience seems to be that women have changed their behavior in the last few years. *Willi* responded that the interpretation of this data is the difficult task that the Council is charged with. *LO* asked about the lack of mental health statistics. *Willi* said it is a delicate subject to ethically do studies on this population, and that the same applies to prisoners and minors.

B. URS (Uniform Reporting System) Utilization Data & Barriers to Service.
Ann Hirozawa, Chief of EES at the AIDS Office, presented the Utilization Data including: 1) background information, 2) data processing steps, 3) number of clients in '97, 4) sites in '97, 5) service categories, 6) limitations of data, 7) advantages/uses of URS data, and 8) analysis of URS data. Data included the following categories: 1) age, 2) race/ethnicity, 3) gender, 4) poverty, 5) health insurance, 6) homeless, 7) primary source of health care, 8) most recent CD4 count, 9) risk group, and 10) median number of encounters by service category, race/ethnicity, health insurance, and homeless status.
Conclusions:
- Includes approximately 80% of clients receiving CARE-eligible service.
- Generalizability of URS data is limited (small number of agencies, many variables not available for all clients).
- Uninsured clients were amore likely to be Latino and to have no regular source of health care.
- Median number of encounters for 7/97 - 12/97 was highest for home health (11 encounters), followed by medical and case management services (5 encounters each).
- No consistent patterns in number of encounters across age, gender, race, health insurance, homeless status.

A packet of information on "Project Reggie" was distributed. This program allows clients of CARE funded services to register once at a participating agency to access services at many other Reggie agencies. It also means agencies will be able to share data more easily. The URS data is a preview of what will be available from the Reggie Program.

Questions: *KB* asked about the median numbers by health insurance and what percentage of sicker patients with higher CD4 counts are on Medi-Cal. *Ann* said that was a good question that they have no answer to at this time. *JB* asked if the Reggie sites were the same or separate from the URS sites. *Ann* said they are the same. *BVB* asked if the populations served will be expanded under Reggie. *Ann* said that by 2000 all CARE funding sites be included in Reggie. *JC* said this is intake data so it doesn't reflect what's happening in the community

The Barriers to Service portion of the presentation included: the 1996 Client Satisfaction/Needs Assessment Survey; agency related and client related barrier categories; overall barriers to receiving services, subcatagories included: 1) medical care, 2) dental care, 3 acupuncture/herbs, 4) rehabilitation (vision), 5) day health/respite care, 6) case manager, 7) legal advise, 8) money management, 9) help finding a place to live, 10) money for rent, 11) money for food or clothing, 12) drug/alcohol treatment program, 13) mental health therapy/counseling, 14) buddy/companion, 15) food, 16) transportation, 17) childcare/summer camp, 18) foster care/adoption, 19) home health care, and 20) hospice care.
Conclusions:
- Overall, clients mentioned behavioral/emotional barriers most often (46% of clients), closely followed by lack of information (43%).
- Types of barriers cited by clients varied widely depending on the service category involved.
- Lack of information was one of the top two barriers cited for 15 out of the 20 service categories.
- Efforts should be undertaker to inform more clients about the availability of services.

It was noted that the informational barriers are the easiest to address and that they are most prevalent among people who have become homeless in the last year.

Questions: *VC* noted that most services are found through word of mouth. *LO* asked what's being done to address the lack of information available to clients. *Ann* doesn't know what's being done about that. *KW* said Marin is tying client services to educational services and outreach. *DB* thought the Council had attached a lower priority to mental health services in the past and wanted to emphasize that mental health funding is important. *DJ* reminded Council members that it is important during the prioritization process to think about what pieces of information are missing. *SO* said that the data the Council heard at this meeting does not help in the decision making process. *DJ* responded that this is the reality and difficulty of the prioritization process. The nature of discussions that need to take place needs to include the experiences of all the Council members.

C. San Mateo & Marin Counties - Demographics & Epidemiology Update.

DJ announced that *JC* and *KW* had agreed to postpone their presentation until Aug. 17, and she apologized to them for the annual time crunch during prioritization. *KW* pointed out that it seems San Francisco doesn't think their contribution is valued. *JC* agreed and said it seems to say something about how San Francisco views its partner counties. *MJW* noted that having the presentation rescheduled to Aug. 17 would not help the members at the Aug. 7 meeting where Marin and San Mateo will be discussed. *WC* stressed the importance of the ideas that Marin and San Mateo bring to the Council.

VIII **Housing Plan Endorsement - VOTE.**
NN passed out the Housing Plan Update Executive and Recommendations Summaries.
NN **moved that the Council endorse the San Francisco Five-Year HIV/AIDS Housing Plan Update. The recommendation passed with a voice vote.** *SO, MJW, LO,* and *VC* abstained.

IX. **New Business:** None

X. **Adjournment:** 7:45 PM

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DRAFT

P=Present; **A**=Absent; **E**=Excused;

	[1]
James Abrams	A
Kirsten Balano	P
MariannaBalquiedra	A
Dorothy Bartolomucci	P
Donald Bliss	P
Jeff Byers	P
Virginia Cafaro	P
Tom Calvanese	E
William Carter	P
Bart Casimir	A
Veronika Cauley	P
Fernando Chavez	P

L=Leave of Absence;

	[1]
Michael Chesek	A
John Conley	P
Mark Dunlop	A
Mariam Farooq	A
Gene Gowdey	P
Diane Jones	P
Susan Karp	A
Tony Leone	A
Steve Lew	A
Allen Meyer	P
Lee Ann Monfredini	P
Norm Nickens	P

Y=Yes; **N**=No; **B**=Abstain

	[1]
Johnnie Norway	P
Lisa O'Connor	P
Loras Ojeda	P
Stephen Oxendine	P
Alissa Riker	A
NildaRodriquez	P
Matthew Sharp	P
Thomas Sinclair	P
Brett VanBenschoten	P
Kelly Wallace	P
Mary Jane Wood	P

DRAFT

HIV HEALTH SERVICES PLANNING COUNCIL

August 17, 1998

The Agenda of this meeting is missing.

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I. **Call to order**: 4:35 PM.

II. **Roll Call** [1]

III. **General Announcements:**

A. *Norm Nickens* announced that James Abrams died over the weekend. There will be a memorial service this Thursday, 6:30 PM, at Bahai Center, 170 Valencia St. The family has requested that contributions be made for his burial expenses. *NN* is accepting contributions on behalf of the family. Checks can be made out to the National Native American AIDS Prevention Center or to Norm Nickens.

B. *Matt Sharp* distributed a flyer for the Pilot Training of the Treatment Education Certification Program, being held Aug. 26-29, at the Asian & Pacific Islander Wellness Center, 730 Polk St., for non-medical, CARE funded, HIV service providers.

C. *Allen Meyer* distributed a flyer for a seminar entitled Living Well with HIV/AIDS, August 24, 1998, Noon, at the SF Main Library, being sponsored by the HERSA field office.

D. *Veronika Cauley* reported having a bad experience at the Emergency Room of SF General Hospital.

E. *Will Carter* apologized to the Latino/a community for his inappropriate remark at the community forum, on July 28, at Theater Brava, where he went to discuss the de-funding of the Vida y Movimiento case management program, and the Council's prioritization process. He also distributed a written apology.

IV. **Public Comment:**

A. *Gustavo Cravioto*, a representative of the Latino community who organized the community forum to discuss the de-funding of Vida y Movimiento, spoke about the pain in the Latino community caused by Will Carter's statement at their meeting. He said there are between 40 and 50 people in the streets with HIV/AIDS now who no longer have case management due to these funding cuts.

B. *Eugenio Dilan* distributed, and read, a letter to Mayor Brown from several Latino/a community groups regarding Mr. Carters's actions the evening of July 28. He added that many people felt that Mr. Carter's behavior throughout his appearance at the meeting was inappropriate.

C. *Maria Rinaldi*, from Instituto Familiar de la Raza, made several points regarding Will Carter's letter of apology: 1. She disputed the statement the Latino/a community has not often been the target of intimidation tactics. She pointed out that many people come from countries where people are killed for expressing their thoughts. 2. There is a problem when the AIDS Foundation and the Planning Council don't pay attention to the clients in the Latino/a community. Mr. Carter should not have defended Pat Christen. 3. The audience at the forum did not misconstrue Mr. Carter's statements. People felt insulted that Mr. Carter came to the forum an hour and a half late, took over the meeting, and imposed himself on the group. She said you do not say "Fuck you" to someone in the Latino/a community unless you want a fight. 4. The meeting was not about the Council's prioritization but about what to do for the people who had lost services. 5. The issue has nothing to do with Mr. Carter being an African American, it's that he acted like he was running the meeting.

D. *Fernando Pachedo* said the Council needs to review the funding cuts that were made to Vida y Movimiento.

E. *Reymundo Anthony*, Chairman of the Board of Aguilas, said that the issue was not about race but respect. The forum was set up by Latinos/as living with HIV, many of whom were tired by the time Mr. Carter spoke but not a single person used a cuss word while addressing the forum except Mr. Carter, the Chair of the Council.

F. *Bill Barnes*, representative of the Mayors Office, in response to the letter sent to the Mayor, said that while the Mayor appoints some members of the Council, he does not have the authority to remove sitting members. Only the Council can remove a member while in office. The Mayor has taken the letter under advisement. He added that he thought the forum was very productive overall.

G. *Peggy Taylor Campbell*, a resident of Leland House, told the Council that there is no wheelchair access to the second floor of the building. There are five people confined to wheelchairs living on that floor. Some of the residents are firebugs and there have been seven fire alarms in the last year. She contacted the city Fire Inspector who referred her to the Bureau of Fire Prevention. She has been unsuccessful in solving this problem. *Michelle Dixon* (AIDS Office) said that *Pam Sims*, Housing Program Manager at the Dept. of Public Health (DPH), will follow-up on this issue.

H. *Elliot Wagner*, Executive Director of California Acupuncture Resources, runs an acupuncture clinic at the Tom Waddell Clinic serving transgender people. He asked the Council to consider funding the clinic.

TC told the people from the Latino/a community that their concerns would be brought up at the next Membership Committee meeting. *TL* moved that the Council send a letter of formal apology to the Latino/a community for having offended them and that it was not the intent of the Council to do that. *JC* said he was not sure that a letter of apology was what the people speaking were asking for. *Maria Rinaldi* said that since Mr. Carter was speaking on behalf of the Council this matter concerned the whole Council, and although an apology was not enough, it was on the Council's conscience to decide whether to extend one or not. *Gustavo Cravioto* pointed out that there are no Latino immigrants on the Council. *Maria Rinaldi* said that more members of the Council should have come to the Latino/a Community Forum set up by the Council. The motion to send a letter of apology to the Latino/a community was passed by the Council. *WC* apologized to the Council for the situation

He said he went to the meeting to assure the Latino/a community that there was a place at the table for them, and he had tried to explain the responsibilities of the Council. He said this was a missed opportunity on his part. He said he would do what he could to protect the Council from any fallout from this situation; how honored he is to be on the Council, and how sorry he is that this has happened.

V. **Marin County Report:**
Kelly Wallace, Executive Director of the Marin AIDS Project, talked about the County as a whole, the agency's services, and where the CARE dollars go. Marin's allocation for last year was $1.5 million. There have been over 1,600 cases since the beginning of the epidemic. That includes about 600 cases at San Quentin Prison. The community cases alone make Marin the highest per capita number of cases for a suburban area in the state. The county is partly rural. The epidemic has traditionally been a GWM epidemic in the county. The county is 83% white, 3% African American, 9% Latino, 5% Asian Pacific Islanders. The cumulative AIDS cases are 6% white, 6% African American, 8% Latino, 2% Asian Pacific Islanders, 92% male, 8% female. Clients of county services are 77% white, 9% African American, 13% Latino, 1% Asian Pacific Islanders, and almost 20% women. On funding: of the $1.5 million, $200,000 goes to support the AIDS Office; alternative therapy gets about 5% for acupunture, vitamin supplements, drugs not on formularies; 7% goes for substance abuse treatment and counseling (They pay for slots in residential drug treatment programs with CARE dollars and follow-up with case management.); 15% goes to emergency assistance, dental funds, and child care funds; 25% goes for case management; 15% goes for benefits and volunteer advocacy; 5% goes for attendant care (There is no housing or hospice care for clients, so they use CARE funds for 24 hour care in patients' homes.), 5% goes to a wellness program; and at least 30% of CARE dollars goes to primary care (There is a specialty clinic for people with HIV/AIDS who are underinsured or uninsured where about 30% of their clients go.). Services in Marin County are very integrated. Marin AIDS Project is the main provider of services including: case management, benefits advocacy, and a volunteer program that provided about $500,000 in services last year including: a) all transportation of clients, b) a massage program, c) hot meal delivery, d) all office, clerical, and reception work. Other agencies assist in providing services to clients as needed. Hospice of Marin has a program for HIV/AIDS patients that will take over case management of clients when necessary. The Marin Treatment Center, a methadone treatment clinic, will also case manage clients who are dually diagnosed. All case managers from the different agencies meet collectively each week to do team case management to determine what clients need. The integration of the system works very well. The agency has combined direct client and educational services in a number of ways, and addresses educational issues of people who are HIV negative as well. There is a Latino outreach worker located in the Canal area of San Rafael, and an African American outreach worker in Marin City whose salaries are partially funded with CARE dollars. Gaps in service are primarily in housing and mental health. Mental health agencies do some volunteer services. The income levels of Marin AIDS Project clients are: 60% extremely low income, 20% very low income, and 8% low income.

NN asked how the state funding stream differed for a rural county. *KW* said they do not get Medi-Caid. They get reimbursement from a rural fund but the reimbursement rates are lower than those of Medi-Caid. The Buck Fund located in Marin provides 11% of the agency's funds, but because of that, other fund raising events exclude Marin from being eligible for proceeds. *LO'C* asked where the housing funds come from. *KW* said they are lucky in having a special grant from HOPWA for helping people in suburban settings with rental assistance. That is why most of traditional HOPWA dollars go into 24 hour care when needed. There is no waiting list for housing now but the special fund will expire in about two years. *LO'C* asked how much money went to the women and children's fund. *KW* said about $40,000. *NN* asked if Marin County had any relationship with the EMA to their north. *KW* said they do not. *GG* asked if they have a periodic competitive bidding process for services in Marin County. *KW* said they do not, usually. *BC* asked if there was any collaboration with Marin General Hospital or College of Marin. *KW* said there was. Marin General is where the specialty clinic was traditionally housed. There has been a liaison there in the past. *MS* asked of the case load in Marin mirrors the health conditions of clients in the rest of the Bay Area. *KW* said it does. *VC* asked if there are transgenders receiving services in Marin County. *KW* said there are but that many transgenders go to San Francisco to receive services for fear of exposure in their community. This is true for much of the HIV/AIDS population in Marin County. *LO* asked if there were statistics on the youth population in Marin. *KW* said that no one under 24 years old was treated last year and that only one case of HIV for the population under 24 was reported, probably for the same privacy concerns affecting the rest of the HIV/AIDS population in Marin. The agency is hoping to do more outreach in schools.

VI. **San Mateo County Report:**
John Conley, AIDS Program Director, San Mateo County Health Services, distributed demographic and service utilization data for San Mateo County for FY 1997-98, and the report of a client satisfaction survey from April 1998 prepared by Mary Jane Wood. San Mateo County has reported 1,704 cases of AIDS since 1981, of these, 613 people are currently living. Estimates are that up to 3,000 people living with AIDS reside in the County. The northern and southeastern parts of the County have the largest AIDS populations. The AIDS cases in San Mateo reflect those of the state and nation rather than San Francisco. African Americans have had the highest AIDS case rates since 1988, but those rates have dropped dramatically the last couple of years. The percentage change in AIDS deaths for all categories has dropped significantly for the last two years. Selected causes of death by race indicate that African Americans have the highest rate of death related to AIDS in the County. Men having sex

with men is the largest exposure group in the County. The total Ryan White Title I fund projected expenditures for FY 1999-2000 are $2,152,832. Pie charts showed, by service provider, the gender, age, ethnicity, annual income, and insurance status of clients. *LO'C* asked why women account for a larger proportion of services (24.5% to 33.5%) than their percentage of the population living with AIDS (15.4%). *JC* said that there were several possibilities: Either the services are particularly accessible and attractive to women, or there are more women living with HIV than are reflected by the figures on women living with AIDS in the County, or that women tend to be over represented along with the poor in these types of services. *LO'C* asked if there were programs that targeted women and children. *JC* said the County has programs for women and children, and that 60% of women receiving services have three or more dependents. Most of the children are HIV negative. One of the services provided is transportation by an agency called Ellipse. The San Mateo County AIDS Program provides vouchers for public transportation. The Help Outreach Team spends much their time transporting clients which give them an opportunity to develop relationships and gather information that might otherwise not be forthcoming. *JC* pointed out that, under ethnicity of clients served, while Whites represent 60.9% of people living with AIDS, African Americans make up 56.3% of those in substance abuse treatment programs. Women are major users of services, which has affected how the programs are shaped. The epidemic is being driven largely by injection drug use in East Palo Alto. There is an underground needle exchange program. Last year, for the first time, the County used a cash incentive to encourage people to get tested for HIV. There were 10,000 tests done, of which 45 were positive, and all but one of those were in East Palo Alto. It's this aggressive outreach that is bringing people into the system. The County went through the RFP process with each of their contractors last year. Each RFP review panel was gender balanced, at least 50% people of color, and 50% people with HIV. Substance abuse services are becoming increasingly important. The new Health Outreach Program is making a positive difference and can bring new clients into the clinic. They have integrated services available in San Mateo, but the challenge is to duplicate those services in other parts of the county. They now have medical services available in Menlo Park that serves about 100 clients. They are providing medical services in Daily City without the other services available at their other sites. The challenge is to expand integrated services on the existing budget.

VII. **Report on Transgender Health Study:** *(get copy of study)*
Kristen Clements, DPH, presented the Transgender Community Health Project study that was prioritized by the HIV Prevention Planning Council. The objective of the study was to determine the prevalence of HIV and risk behaviors in the San Francisco transgender community. To be eligible for the study, people had to be 18 years old or older, and live or spend time in San Francisco (89% lived in SF). Their primary gender identification had to be transgender. Seven agencies and three bars helped in recruitment. They also did "snowball" recruitment with participants in the study. There were 605 eligible candidates, of which 90% showed up for their appointment. Interviews were held at agencies. Five hundred and fifteen eligible participants completed the survey and all agreed to be tested for HIV. The median age was 35. In the male to female population a little over half had stable housing, 40% were currently homeless (that number is much higher when looking at the last year). Female to male population had more stable housing. The median monthly income in the male to female population was $740 with the most common jobs cited being sex work. The female to male median income was $1,100. About a third of the male to female, and 15% of the female to male populations were born outside of the U.S. Gender identity: 37% of both, male to female, and female to male identified themselves as transgender; 27% of male to female, and 21% of female to male identified themselves as transsexual; people who identified themselves as male or female thought of themselves as, secondarily, transgender or transsexual. HIV prevalence among male to female population is 35%; under 2% for the female to male population. Of the male to female population who were HIV positive, 35% found out for the first time in this study. This was the group that the study focused on getting into services. Of the sample, 78% were receiving some form of health care. The rate of HIV prevalence by ethnicity shows that the African American population has the highest rate at 62%. This finding remains when controlling for other factors. Risk behavior was much higher in those who were HIV positive. The percentage of people engaging in unprotected anal receptive intercourse is higher than in other populations. Injected drugs and hormones are playing a role in infection. Recent risk behaviors in HIV positive population tends to get riskier once they know their status.

LO asked if there were barriers being reported by the agencies working with this population. *KF* said there were barriers that could be reviewed a later reading of the material. *NN* commended Kristen and the staff who worked on this study and suggested having them back to talk about barriers and other issues they discovered in the study. *MS* asked what was used as an incentive. *KF* said there was a $40 incentive for the interview and HIV test. The returnees got $10. If participants recruited their friends they got an additional $5 for each one who participated *Peggy Taylor Campbell* asked if there was going to be more education for this population based on the study's findings. *KF* said the HIV Prevention Planning Council has already made some changes based on the study. There are five agencies that have some level of outreach to this community. *Bill Barnes* noted that the age group was for over 18 and wondered if including that age group would change the outcome of the study. *KF* said they were being careful to choose a population that had determined their sexual identity. Younger people are often still experimenting and have not made that determination yet.

VIII. **Prioritization Plan 1900 - 2000:**
Handouts: AIDS Council Orientation Agenda; Recommendations for prioritization; Emerging Consensus; Definitions of Harm Reduction; 1999-2000 prioritization plan - under served populations and barriers; Spread sheets for CARE funded service categories.

TC reviewed the agenda for the meeting and the prioritization process leading up to this meeting. He noted that Council members should have received an Index of Community Forum meetings in the most recently mailed packet as well as Task Force meeting notes from last week's meetings.

VC asked that the Council keep the Transgender community in mind as an under-served population during the prioritization process.

TC explained that the Steering Committee was unable to agree on a cohesive plan to present to the Council from the information gathered at the Community Forums and the Task Force meetings, so they put together the Emerging Consensus document which is a synthesis of the issues that consistently came up during the meetings of the previous weeks. Housing has emerged as the most pressing unmet need in the HIV/AIDS community which, in itself, creates barriers to other services. The three main themes that emerged during the process were: 1. Integration of services including: services to clients where they are; multiple services provided at single sites by a team of providers; consolidation of contracts and integration of funding streams; housing as a fundamental component of an integrated service array, and as a focal point (along with Health Care) around which services must be made available. 2. Outreach/Information including: need to reach marginalized populations; information, referral, and education about the system of care for both clients, potential clients and service providers; strategies carried out in a manner culturally and linguistically appropriate for the populations being targeted. 3. Outcomes/Outcome Measures including: Client centered and defined in relationship to a) access to treatment and other services; b) adherence to care; c) quality of life; d) quality of services.

TL said there are multiple barriers to adherence all of which are not client related. *TC* said that the question of harm reduction came up repeatedly during the Substance Abuse Task Force meeting. Members of that meeting requested clarification of what was meant by that term. *KW* pointed out that, in the document describing under-served populations and barriers, there are two pages titled Mental Health Task Force. The second page should be entitled Substance Abuse Task Force. *TC* described the spread sheet as a synthesis of ideas from the Task Force meetings into recommendations that the Council can use in the prioritization process based on the four possible funding scenarios. *KB* said to think of the spread sheet as a worksheet or starting point. *LT* said the document reflects what people have said during meetings over the last month. If definitions used on the spread sheet are not clear, refer to the Prioritization Plan notes for more detailed information. Some suggestions conflict, so each Council member needs to do some homework and determine for themselves what makes a sound proposal for each of the funding levels, in each of the service categories. She referred to the 8/17 Recommendations for prioritization as guidelines for the Council as they move through the process; the information from the CARE Application Guidance is useful to keep in mind when prioritizing funding because the grant proposal will have to reflect those issues. *TC* urged Council members to go over the information carefully and be prepared, at next week's meeting, to make decisions on funding priorities. The following week the Council will make final decisions on actual dollar allocations. He noted the need for a timeline to insure completion of the plan. He suggested Council members consider the two lists of recommendations for prioritization, one from the HIV Contractors Association, and the other from the PWA Caucus. *KW* asked that if there was increased funding that Marin and San Mateo be included in the funding increase. *KB* stressed that the spread sheet was really a worksheet. *Jim Illig* said that the Task Force meetings were brainstorming sessions and that there was no consensus on some of the issues listed in the notes and on the spread sheets from those meetings. *TC* said there was consensus on many items, he suggested that Council members read the notes carefully and ask questions. *LO'C* said the harm reduction handout is missing information about the principles of harm reduction. *TC* said he would work on gathering more information on that subject.

X. **New Business:** None

XI. **Adjournment:** 7:45 PM

DRAFT

The Council meets on the third and fourth Mondays of each month, at the time and place noted above. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For HIV-Positive members requesting excused absences due to illness, contact Tom Calvanese at 621-7712. *Minutes of meetings are tentative until formally approved by the Council.*

P=Present; **A**=Absent; **E**=Excused;

	[1]
James Abrams	
Kirsten Balano	P
Marianna Balquiedra	P
Dorothy Bartolomucci	A
Donald Bliss	P
Jeff Byers	P
Virginia Cafaro	P
Tom Calvanese	P
William Carter	P
Bart Casimir	P
Veronika Cauley	P
Fernando Chavez	P

L=Leave of Absence;

	[1]
John Conley	P
Mark Dunlop	E
Mariam Farooq	A
Gene Gowdey	P
Diane Jones	A
Susan Karp	A
Tony Leone	P
Steve Lew	A
Allen Meyer	P
Lee Ann Monfredini	A
Norm Nickens	P

Y=Yes; **N**=No; **B**=Abstain

	[1]
Johnnie Norway	P
Lisa O'Connor	P
Loras Ojeda	P
Stephen Oxendine	P
Alissa Riker	P
Nilda Rodriquez	P
Matthew Sharp	P
Thomas Sinclair	P
Brett VanBenschoten	P
Kelly Wallace	P
Mary Jane Wood	P

DRAFT

HIV HEALTH SERVICES PLANNING COUNCIL

August 24, 1998

The Agenda of this meeting is missing.

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I. **Call to order**: 4:50 PM.

DRAFT

Roll Call [1]

II. **General Announcements:**

A. *Diane Jones* announced that Veronika Cauley named Tom Calvanese as proxy holder in her absence, and distributed a letter to the Council from Veronika.

V. **Public Comment:**

A. *Steve Anderson*, Administrative Manager, Walden House HIV Services, distributed statistics regarding Walden House CARE Residential programs for substance abuse.

B. *Laura Feren*, Family Service Agency of San Francisco, read a letter written to the Council from James Dilley, Executive Director, UCSF AIDS Health Project, and signed by representatives of eight mental health providers. The letter recommended: 1) Holding the Mental Health category harmless from any additional cuts. 2) Maximizing Medi-Cal revenues. 3) If a funding cut is necessary, cutting from underutilized services. Additionally the letter suggested not cutting funding for an inpatient psychiatric bed at SFGH; not lowering the reimbursement cap for services because those reimbursement rates are almost identical to existing rates for CMHS (Community Mental Health Services) and CARE contracts; and not cutting services to the severely mentally ill. Due to the complexity of psycho pharmacology in caring for people on combination therapy this population should remain within CARE funded services. The recommendation to cut funding for this group will be unnecessary if the Medi-Cal maximization plan is implemented.
DJ noted that most mental health services were not underutilized. *Laura Feren* asked that the focus of cuts be on the underutilized services even if they were not greatly underutilized.

V. **Prioritization Plan:**

Laura Thomas, AIDS Office, distributed: 1) a memo regarding the percentage of funding for women and children receiving Title I funds. Women, children, and infants make up 5.5% of people living with AIDS in this Eligible Metropolitan Area (EMA), and the percentage of CARE funds spent on them is 17.8%. 2) a news release from the California Dept. of Health Services regarding the expanded list of AIDS drugs in the new state budget. The expansion of the AIDS Drug Assistance Program (ADAP) formulary is significant to the Council because it means that ADAP will now pay for some of the drugs that have traditionally been funded under a non-ADAP line item, so the demand for that line item will probably be less. 3) The SF EMA Service Category Priority Order for FY 98-99. *DJ* asked why this list is necessary. *LT* said it's required for the grant. *DJ* said it has no implication for funding. It's a Health Resources and Services Administration (HRSA) requirement. *JB* said in other EMAs this list becomes more important because they follow a formula for determining funding. *DJ* said it does reflect our priorities but not necessarily in the order listed. *LT* noted that items 7-13 are listed on the spread sheets as Other Support Services. *JB* asked why the terms "pharmaceuticals", and "alternative & complementary treatment" are used under Health Care instead of the HRSA definitions. *LT* said that San Francisco put a number of services into the Health Care category last year because of the integration of services. They do not strictly follow the HRSA definitions that will be used when writing the grant proposal. *TS* said the Dept. of Consumer Affairs classifies acupuncture under primary health care.

• *KW moved that the Council accept the San Francisco EMA Service Category Priority Order for FY 98-99.*
The motion passed unanimously. [2]

BC voiced concern about the term "alternative therapies" and suggested "complementary therapies". There was no objection from the Council. *LO* noted that under Health Care the sub-category Vision Impairment is included in the Task Force spread sheet but not in the worksheet distributed to the Council last week. *LT* said the provider declined to continue providing the service. *DJ* asked to put the discussion of that issue off until the Council reviewed Health Care.
TC reviewed the handout of Definitions meant to clarify the intent of the recommendations contained in the 1999-2000 prioritization plan:
INTEGRATION was described as being either "vertical", where comprehensive services are provided within a single agency or program and coordinated internally, or "horizontal", where comprehensive services are provided by a collaboration of several providers, each contributing expertise within a certain service area, and coordinated among these several providers. *TC* said the Council is not dictating how integration is accomplished but suggesting what is to be accomplished. There are many models for reaching the goals of the Council.
LINKAGES refer to working connections, not to MOUs. They can refer to ties between solely CARE funded programs, or between CARE funded programs and programs funded under other funding streams.
CONSOLIDATION refers to consolidation of contracts and integration of funding streams that simplify the paperwork and facilitate further integration of services. These three terms are often used collectively. *MS* asked if these definitions were just for the Council's use or are they going to be used publicly, and if so do they need to be voted on. *DJ* said it doesn't require a vote, just a consensus of the Council. *LO* thought there should be more conversation about these terms. During one of the Task Force meetings there was disagreement among the

providers as to the meaning of the terms integration and consolidation. He said some people think consolidation is easier and more cost effective than a horizontally integrated model. DJ said the Council needs to keep a distinction between what it is they want to see happen and the implementation of how that takes place. The Council's job is to determine what needs to happen, the AIDS Office will work with the contractors on implementation and the Council's roll then is to evaluate the situation to see if it's achieving the goals of the Council. *LO'C* said the descriptions are well defined. *KW* asked why the term "multi-year" is not being used this year. *DJ* said the Council is in year two of a multi-year plan. *TC* said that because last year's plan was so ambitious there are components of it that may take several years to put in place. BC said that the definitions also refer to the Council's efforts to eliminate duplication of services. *DJ* said there is built in resistance to change and it is the job of the Council to advocate for the system to respond to the needs of the people. The Council is the driving force behind change. *Sauda Burch* asked Council members if they could accept the definitions of integration, linkages and consolidation. There was no opposition to the definitions. *TC* said these definitions were not cast in stone and could be reviewed in September when the Council examines implementation issues.
ADHERENCE, in the context of the 1999-2000 prioritization plan, usually refers to a planned dosing regimen for drug treatments. However, a broader definition applies to treatment plans for other services as well. *MS* asked how adherence relates to compliance. He said that for contract language it may be clearer to use "compliance". *KB* agrees with the expanded definition because it applies to more than access. *TL* said there are multiple barriers to adherence and that they come from the providers side as well. *TC* referred the Council to the definitions in the Emerging Consensus document. The Council agreed to the definition of adherence with some fine tuning.
HARM REDUCTION has no universal definition. *TC* said there is no necessity for the Council to agree on the definition of this term. In the context of the 1999-2000 prioritization plan, harm reduction may be taken as applying to a variety of services and how those services are delivered to individuals in need. Those services must be carried out in a manner that is culturally and linguistically appropriate for the populations being targeted, and must be client-centered and client-defined in terms of quality of life and positive life changes for clients, as well as quality of services and service providers. A loose definition is reaching clients "where they're at". *BC* said that the Treatment on Demand Council accepts harm reduction as a concept that is being developed to meet the client where they are around services. There is a controversy because some providers believe harm reduction should equate with abstinence. *LO'C* said she likes this definition better because it allows for a variety of views about what harm reduction is. *DJ* said the DPH is sponsoring a conference on harm reduction in February. *KW* pointed out that where clients "are at" does not just mean physically. It involves helping clients over psychological hurdles as well. The Council agreed to using this working definition of harm reduction.

VI. **Membership Committee Report and Recommendations:**
Michael Chesek, Chair, Membership Committee, HIV Services Planning Council, reported on the nominations to fill the current vacancies on the Council. Two of the seven open seats are mandated slots, one of which must be filled by a representative from Medi-Cal, and the other by a representative of Title IV funded agencies. The remaining five seats are open positions and the Committee recommended the following individuals for appointment to these seats:
Jorge Ortiz, a Latino, HIV-positive consumer of CARE funded services.
Laura Carcagno Guzman, a Latina, HIV-negative, bi-sexual, Outreach and Training Coordinator at AIDS Benefits Counselors.
Susan Shea, an Irish, HIV-negative, lesbian, nurse practitioner in the UCSF AIDS program.
Eric Whitney, a White, HIV-positive, gay, former consumer of CARE funded services.
Siddiq Jihad, an Afro-Latino, HIV-negative, heterosexual, coordinator at the TARC Bridge Project.
In addition the Committee recommended the following individuals for consideration:
Barry Savage, a former member of the Council.
Julie Charubusapayon, a pediatric HIV clinical social worker in UCSF's Women & Children's Specialty Program.
Richard Apodaca, an HIV-positive, Latino consumer of CARE funded services.
The Committee voted to support the two individuals whose names were submitted for the two mandated seats,
Carol Gong as the Medi-Cal representative.
Chris Boehm as the Title IV representative.

Michael Chesek passed around a letter from Carol Gong stating her willingness to be on the Council but also explaining the time limits she had and her inability to commit to coming to all Council meetings. *Bill Barnes,* from the Mayor's Office, said he spoke with Carol and that the Council is required by federal law to have a representative from Medi-Cal as a Council member, but since the state does not recognize that as part of Carol's job, there may need to be further legislation. *Michael Chesek* discussed the analysis of the Council demographics, and said the Council is slightly underrepresented by Latinos and Whites. *TS* requested the Council to move Barry Savage's name to the top of the list. *SO* asked why Barry Savage was dropped from the Council. *Bill Barnes* said the Mayor has the option not to reappoint members of the Council and he chose not to reappoint Mr. Savage. If the Council thinks he would be a good choice they can forward his name to the Mayor. *TS* said that both the Membership Committee and the Council sent letters to the Mayor's Office requesting Mr. Savage be reappointed to the Council. *DJ* said there was a motion on the table to vote on these recommendations and asked if anyone had any comments. *LO'C* said she was uncomfortable with submitting Carol Gong as a candidate based on the conversation of the Council. *SO* asked how many African American women were on the Council. *DJ* said there

were two. *DB* said she was uncomfortable with Susan Shea based on personal experience. *WC* asked if there was a conflict of interest for members of the Council who had personal experience with nominees. *DJ* said it was not a conflict of interest. The Council agreed to amend the recommendation to include Barry Savage's name on the list of strongly recommended individuals. *BVB* said that he no longer meets the definition of a youth with HIV, he requested that the Membership Committee keep in mind Youth as an underrepresented category on the Council.
• *DJ called for a roll call vote to accept the Membership Committee's nominations for Council seats.*
The vote passed with one abstention. [3]

DJ thanked Michael Chesek for his work on the Membership Committee. *Michael Chesek* noted there was a letter of resignation from Steve Lew, and reminded Council members to keep Native Americans, Youth, and consumer representatives in mind for future membership.

I. **Prioritization Plan - Part 2:**
TC reminded the Council that the Evaluation Committee had suggested applying any funding cuts proportionally across service categories. He said that cuts should be applied within each category according to the recommendations of the Task Force noted on the spread sheets. Where there are conflicting recommendations the Council will have to decide how to apply cuts. One recurring recommendation that came out of all the Task Force meetings was not to apply cuts to programs that have just been created. *DJ* said that this approach would mean that no service categories would be held harmless. *KW* asked the Council to hold Marin harmless even if there was a cut. *SO* asked how the Council determines the amount of dollars to ask for in the grant proposal. *LT* said they would be creating a budget in the range of $40 million. That figure will be arrived at by putting together all the increased budget scenarios. *Michelle Dixon*, Dir. of Health Services, AIDS Office, suggested using a category as an example of how the process would work. *LT*, using Housing as an example, said that category makes up 19% of the total budget, so if there was a cut to the total budget of $1 million then there would be about a $200,000 cut in Housing. The Council will determine which Housing sub-categories that cut will come from. The AIDS Office would implement those cuts based on the Council's recommendations. *SO* said he still wondered where the bottom line amount came from. *WC* said that the level funding scenario is where the bottom line numbers come from based on what was done last year. It was pointed out that Marin and San Mateo counties cannot be included in discussion of cuts to programs. *JN* asked if any sub-categories would be eliminated through proportional cuts. *TC* said that would not happen because sub-categories with less funding would have smaller cuts. *DB* voiced concern about not holding Mental Health and Case Management harmless since they had substantial cuts last year. He was also concerned about holding new programs harmless. *TC* said to look for a broad approach to the question of what to do if there is less money. He thinks there will not be substantial cuts this year and that the recommendations before the Council apply under those conditions. *TL* asked for a motion.
• *TC stated the motion, "To apply any decrease in funding proportionally across service categories according to the decreased funding recommendations within each service category, with the exception of new services, Marin and San Mateo Counties."*
The motion passed with two No votes. [4]

A. Health Care:
LO asked why Vision Impairment was deleted from the list of Health Care sub-categories on the spread sheet. *LT* said the provider who was covering that service declined to continue providing service due to the reduced demand for service and the amount of paperwork required for the money, so the $40,000 that went to that service is not included in the baseline budget for this year. The contractor provided rehabilitative services to help people suffering from loss of vision due to CMV Retinitis adapt to that condition. Some of the service is still being provided, but not with CARE dollars. Vision Impairment still exists as a service category even though it is not shown on the spread sheet. *TS* spoke in favor of including Vision Impairment in the budget. *JM* said that the service is still available, it's just not being funded through CARE dollars. *TL* asked what happened to the money that was budgeted for this item. *Michelle Dixon* said that when there were savings within a category last year they were used to extend programs that had been cut to allow clients to continue receiving services until they could transfer to new programs. *KW* suggested this issue be resolved instead of creating a list of questions that need coming back to. *TC* asked that the Council come back to this question when they are less pressured for time. *JN* asked if both newly integrated services and services yet to be integrated would be exempt from cuts. *TC* said both services that have been moved into an integrated system through the RFP process and services that will be moved in that direction this year will be held harmless. He asked the Council if they could agree to making cuts in Health Care according to the motion that had passed to make cuts proportionally to all sub-categories. *DJ* pointed out that the only recommended funding cut in the Health Care category was for non-ADAP medications and that the reason for this recommendation is that this sub-category receives non-expended funds from other areas at the end of the fiscal year. *JB* asked how hard it is to determine what funding is involved in integrated service programs if they are to be held harmless. DJ said that the bulk of funds are still going to non-integrated services. *JB* pointed out that with the newly expanded state formulary of ADAP drugs there will be less need for funding that sub-category. *KW* suggested residential facility based services in the Home Health sub-category be held harmless. *AR* mentioned the Evaluation Committee's recommendation to focus cuts on sub-categories that are underutilized or have unexpended funds from FY 97-98. She suggested looking at the Department of Public Health

(DPH). for where cuts could be made. *JN* noted that the Task Force recommended the new services under the Dental sub-category be held harmless. *TS* said that last year the sub-category Complimentary Care was cut by $100,000.00 primarily based on utilization data that was inaccurate, and asked that this sub-category be held harmless this year. *KB* said that it seems the sequence of the prioritization process is, first to decide if proportional cuts are to be made to each service category, and after that decision is made the Council will look at utilization data to determine what the reduction scenario for each sub-category will be. *WC* said what's important to keep in mind is whether the Council's funding decisions are going to meet the needs of the community in the next fiscal year. He pointed out that data indicates the death rate from AIDS is plunging and wondered what that means for services that people are going to need. *DJ* said there are two recommendations to keep in mind regarding the Health Care category: 1) Continue integration of services. 2) Divide services in the Home Health sub-category into home-based, and residential facility-based; expand the definition of what home-based services are beyond the narrow definition that Medi-Cal pays for; reorganize services so residential facilities have direct control over their services. She made a motion that the Council approve the content of these recommendations which would apply regardless of funding changes. She said there weren't contradictions within the Task Force as to these recommendations. *TL* pointed out that proportional cuts could mean that programs might be eliminated unintentionally. He said that programs with fixed costs need to be held harmless.
The question was called whether to have a vote on the proposed motion.
The vote passed with three No votes. [5]

- *The motion was "To accept the recommendations for the Health Care category, and to distribute proportional cuts across all the sub-categories after having eliminated the Pharmaceuticals sub-category, and holding harmless residential licensed facilities within the Home Health sub-category, the newly funded programs in the integrated services delivery model and the Dental sub-category."*

The motion passed with four No votes. [6]

KW said it's important for Council members to bring up issues as they see them fitting into the discussion. The question arose of when the discussion of Vision Impairment would come before the Council. *DJ* suggested that people who wanted to stay and figure out how the process should work for next week's meeting do so. *LT* pointed out the prioritization work of the Council needs to be done by the end of the next meeting. *TS* encouraged the Chair to recognize people who are waiting to speak, and said he did not want to see the process rushed and was willing to spend whatever time it takes to complete the prioritization plan.

VIII. **New Business:** None

IX. **Adjournment:** 7:45 PM

The Council meets on the third and fourth Mondays of each month, at the time and place noted above. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For HIV-Positive members requesting excused absences due to illness, contact Tom Calvanese at 621-7712. *Minutes of meetings are tentative until formally approved by the Council.*

'/24/98 HIV Services Planning Council Meeting

P=Present; A=Absent; E=Excused; L=Leave of Absence

	1	2	3	4	5	6
Kirsten Balano	P	Y	Y	Y	Y	Y
Marianna Balquiedra	P	Y	Y	Y	Y	Y
Dorothy Bartolomucci	P	Y	B	Y	Y	Y
Donald Bliss	P	Y	Y	N	N	N
Jeff Byers	P	Y	Y	Y	Y	Y
Virginia Cafaro	P		Y	Y	Y	Y
Tom Calvanese	P	Y	Y	Y	Y	Y
William Carter	P		Y	Y	Y	Y
Bart Casimir	P	Y	Y	Y	Y	Y
Veronika Cauley	E	Y	Y	Y	Y	Y
Fernando Chavez	P	Y	Y	Y	Y	Y
John Conley	P	Y	Y	Y	Y	Y
Mark Dunlop	E					
Mariam Farooq	A					
Gene Gowdey	P	Y	Y	Y	Y	Y
Diane Jones	P	Y	Y	Y	Y	Y

Y=Yes; N=No; B=Abstain

	1	2	3	4	5	6
Susan Karp	A					
Tony Leone	P	Y	Y	Y	Y	Y
Allen Meyer	P	Y	Y	Y	Y	Y
LeeAnn Monfredini	A					
Norm Nickens	P	Y	Y	Y	Y	Y
Johnnie Norway	P		Y	Y	Y	Y
Lisa O'Connor	P	Y	Y	Y	Y	Y
Loras Ojeda	P	Y	Y	Y	Y	N
Stephen Oxendine	P	Y	Y	Y	Y	N
Alissa Riker	P	Y	Y	Y	Y	Y
Nilda Rodriquez	A					
Matthew Sharp	P	Y	Y	Y	Y	Y
Thomas Sinclair	P	Y	Y	Y	N	N
Brett VanBenschoten	P		Y	Y	N	Y
Kelly Wallace	P	Y	Y	Y	Y	Y
Mary Jane Wood	A					

DRAFT

HIV HEALTH SERVICES PLANNING COUNCIL

August 31, 1998

The Agenda of this meeting is missing.

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I. **Call to order**: 4:35 PM.

DRAFT

II. **Roll Call [1]**

III. **General Announcements:**

A. *Tom Calvanese* said he is acting as proxy for *Veronica Cauley* and *Tom Sinclair* at this meeting. He also said *Will Carter* may not be at the meeting due to health problems.

B. *Bart Casimir* attended a meeting of the Treatment on Demand Council. They just put out an RFP for gay men using methamphetamines.

C. *Lisa O'Connor* said she participated in a three day training for the Treatment Education Certification Program that was very informative.

D. *Michelle Dixon*, Dir. of Health Services, AIDS Office, said the AIDS Office is accepting letters of intent for RFPs for youth, peer counseling, and methadone maintenance. The due date for the letter is September 1, 1998. Solicitations will not be accepted without a letter of intent.

V. **Public Comment:**

A. *Chris Boehm* asked why Youth, which was named as a priority population by the Council last year, was not funded by the AIDS Office. *DJ* said the AIDS Office did not de-prioritize Youth. The review panel chose not to fund youth specific services based on the evaluation of the proposal. *Michelle Dixon* said the AIDS Office has a call out for letters of intent for RFPs providing Youth programs because they realized there was a gap in that area.

DJ noted that the Council's emphasis on public forums and input this year has paid off in the sense that there were not many people here to speak during the Public Comment segment of this meeting. In past years there have been large numbers of people wishing to speak as the prioritization deadline approached.

V. **CARE Prioritization Plan 1999-2000:**

Handouts: 1) agenda; 2) 1999-2000 CARE Prioritization detailed agenda; 3) Emerging Consensus document; 4) Annualized Title I RFP for FY 98-99 that shows $ amounts being held harmless due to new programs, and the amounts available for reduction; 5) category spread sheets based on the task force recommendations.

TC said any reductions in funding this year probably will not be large. He reviewed the document (handout #4) that shows which sub-categories have portions that are being held harmless due to new programs. The total amount being held harmless is $8,418,278; the balance amount of those sub-categories is $8,983,958; the total CARE budget is around $36,000,000, so the total amount that cuts will need to come from is about $27,000,000.

LT noted that Marin and San Mateo Counties are also being held harmless. Once all held harmless funds are removed from the budget a 5% cut in funding becomes about a 12% cut to the affected sub-categories.

DJ said that the Council is going to use parliamentary procedures to help get through the decision making process of this meeting. Council members will be held to using motion procedure to make decisions. The basic proposals are contained within the detailed agenda. The Council needs to focus on voting on these motions and making amendments to them. *TL* distributed a simplified guide to parliamentary procedures and explained the process.

The 1999-2000 CARE Prioritization detailed agenda (handout 2) is structured in the form of proposed motions for the Council to vote on. Each numbered item is a service category; within each service category are two subheadings titled Programs and Reductions; the bulleted items within each subheading comprise a motion. There can be only two amendments to a motion on the table at any one time; an amendment to the motion, and an amendment to the amendment. All substantive motions must have a role call vote. The order of voting is to vote on the amendment to the amendment first, the amendment second, and lastly the motion. The motion is restated before the roll call. The category spread sheets (handout 5) list the proposed strategies and funding scenarios based on the task force recommendations.

TC reviewed the motions that were passed at last week's Council meeting: Reductions In Funding and Primary Care.

MOTION PASSED AT 8/24 COUNCIL MEETING:

REDUCTIONS IN FUNDING will be made proportionally across all service categories with the following considerations:

- **Cuts will be made according to the task force recommendations approved by the Council and applied first within sub-categories where funds were left unexpended.**
- **Hold harmless programs newly funded in FY 98-99.**
- **Hold harmless San Mateo and Marin Counties.**

1. **PRIMARY CARE**
MOTION PASSED AT 8/24 COUNCIL MEETING:
Programs:
- **Pursue and expand integration of services at primary care sites.**
- **Expand the definition of home-based services and use CARE funding to fund those services not funded by Medi-Cal.**
- **Allow residential facilities to subcontract for their nursing and attendant care.**

MOTION PASSED AT 8/24 COUNCIL MEETING:
Reductions:
- **Cut *pharmaceuticals* [the original word was pharmacy] services first.**
- **Hold harmless new programs and home care for residential facilities.**
- **Make proportional cuts across sub-categories.**

Implementation issues: Vision Care

2. **HOUSING**
TC noted that the Council has benefited from having a Housing Committee the last couple of years to focus on integration of funding with other agencies, specifically Housing Opportunities for Persons With AIDS (HOPWA). He said there were clear recommendations from the Housing Task Force except for the question of cost of living increases (COLAs) for contractors . All sub-categories move further toward integration of services. There was consensus on protecting residential facilities with fixed operating expenses in the event of funding cuts.

PROPOSED MOTION:
Programs:
- **Adopt Housing Task Force recommendations with the exception of COLAs.**

LO'C asked for clarification about the sub-category Support Services: Financial. *Michelle Dixon* said it was a form of money management. *TC* said it fell under the broad category of further integrating services. He reminded Council members to refer to the Emerging Consensus document because most of the proposed strategies on the task force spread sheets fall under one of the three themes listed there: integration of services, outreach/information, and outcomes/outcome measures. *KW* asked if new programs could be indicated in some way. *LT* said that if a program has only a plus sign under the increased funding column on the task force spread sheet, and no other funding indicators it's probably a new program.
The motion as stated passed with one no vote. [2]

PROPOSED MOTION:
Reductions:
- **Proportional across all sub-categories.**
- **Hold harmless residential facilities.**

BVB asked what residential facilities referred to. *TC* said it covered residential hospice and facilities that are subsidized. *Michelle Dixon* asked if rental subsidies are being held harmless. *DJ* said only those that are tied to facilities or new programs. *BC* asked what the minus sign meant in the decrease funding column of Residential Hospice that says hold harmless-no cut. *TC* said that indicates the priority if there were a decrease in funding. *LO'C* asked if residential facilities included programs like Derek Silva. *DJ* said they do.
The motion as stated passed unanimously. [3]

3. **MENTAL HEALTH**
PROPOSED MOTION:
Programs:
- **Continue integration with other services; provide mental health services in non-mental health service sites (include primary care, substance use, housing, street-based, drop-in and after hours).**
- **Improve early mental health assessment for better triaging of clients to appropriate services.**
- **Improve outreach and publicity around existing services.**
- **Improve the capacity of existing programs to address the needs of individuals with dementia/cognitive impairment.**
- **Continue efforts between CARE funded programs, Community Mental Health Services (CMHS), and the Department of Public Health (DPH) to configure funding streams to allow Medi-Cal and CARE funding maximization.**

• *TL moved to amend the word "drop-in" (in parenthesis under the first bullet) to say "drop-in centers which provide comprehensive services and referrals."*

NN asked for a definition of "comprehensive services." *TL* said it was a range of HIV services including: the ability to do psychiatric assessment, referral to psychiatric services, mental health services, referral to substance abuse services, referral to case management and money management that would be provided at a drop-in center. *NN* asked if these services were provided on-site or were referrals. *TL* said the site would do both. *SO* asked if this would mean creating a new program. *DJ* said that would be a question of implementation. *LM* asked if the term "after hours" meant around the clock. *TL* said it did not necessarily mean 24 hours, but more than 9 AM to 5 PM, or arranged in a different way. *KW* asked if every site needed to provide all of these services. *DJ* said that in addition to mental health sites there would be mental health services in non-mental health sites. In some cases this has already happened. *LO* asked what the basis for the amendment is. *TL* said the idea of drop-in centers needs to be more integrated and provide more services. *KB* opposed the amendment and suggested including it in the Emerging Consensus document, under the second bulleted item in Integration of Services. *TL* opposed that proposal. *BC* asked what would happen in the long and short term mental health services sub-category when the $850,000 rollover request to the Health Resoruces and Services Administration (HRSA) expires in February 1999. [The Director of the DPH has committed to identifying General Fund dollars to insure the continuation of these services after February 1999.] *LO'C* supported the amendment, but suggested clarification in the case that drop-in centers would be considered new services. *DB* said the subject needed more discussion and opposed the amendment. *TC* spoke in favor of the amendment saying the Mental Health Task force and the community forums supported extended services in drop-in centers. *KW* was opposed to the amendment. *BC* approved the amendment. *NN* was against the amendment as worded. *MD* supported the amendment based on public opinion. *LO* was against the amendment because it is limited in scope.

• *KB moved to amend the amendment by substituting the term "continuum of care" for "comprehensive."*

The motion to amend the amendment failed, the vote was 12 yes, 14 no. [4]

The motion to amend the motion failed, the vote was 14 yes, 12 no. [5]

The motion as stated passed unanimously. [6]

PROPOSED MOTION:

Reductions:

- **Cut proportionally across all sub-categories starting with under-utilization.**
- **Hold harmless newly funded programs.**

• *TC proposed an amendment "to lower the reimbursement cap for services in the long and short term mental health services sub-category under any funding scenario."*

AM asked what the current reimbursement cap is and what the Medi-Cal rate is. *Russ Zellers*, Asst. Dir. of Health Services, AIDS Office, said the AIDS Office is unsure about those figures. *TC* emphasized that he did not say the cap should be closer to Medi-Cal, but that it should be lower than it currently is. *LO'C* asked if the reimbursement cap would be lowered before proportional cuts were made in the entire Mental Health category. *DJ* said it would. *KB* asked if this motion was needed in addition to the motion that was passed to continue efforts between CARE funded programs, CMHS, and DPH to configure funding streams to allow Medi-Cal and CARE funding maximization. *TC* said he supported that motion but it doesn't address the question of the reimbursement rate. *DB* asked for clarification of *AM*'s question what the reimbursement cap is. *TC* said it depends on what the service is. *Russ Zellers* said that the cap for non-psychiatric services is about $100, and for psychiatric services about $150. *KW* asked, about maximizing funding streams, if it means that agencies who qualify would get the Medi-Cal rate or would the Council continue to subsidize that rate up to the CARE rate. *Michelle Dixon* said if the motion is implemented it's hard to say what the outcome will be, but there will be a direct effect as opposed to the previously stated motion which may or may not have an immediate effect. *DJ* said that the Mental Health Task Force asked that major changes not be made now, which is the reason for the wording of the motion "to continue efforts between CARE funded programs, CMHS, and the DPH to configure funding streams to allow Medi-Cal and CARE funding maximization." *DB* asked Russ Zellers if the rate was based on units of service rather than per hour because there is more involved in a unit of service than the time the service takes. He spoke against the motion because more information is needed to discuss the issue. *JB* echoed that concern. *TC* said he knew there were things that needed to be worked out but was asking Council members to vote for the spirit of the measure if they agreed with it. *KB* spoke against the motion because the continued efforts that have been voted on can include this effort in a more positive way. This motion sounds like another negative directive from the Planning Council. *BC* spoke in favor of the motion because it means that people who are falling through the cracks will be included in services and allow for treatment of more people. *LO'C* spoke against the motion because the rates are too low already. It's hard for programs to keep therapists because of the low reimbursement rates. *LO* spoke in favor of the motion because it equalizes the cost of like services. *NN* spoke against the motion because the way it's worded now it's a mandate to lower the costs.

• *NN offered an amendment to the amendment to read "Assess and negotiate lower reimbursement caps for long and short term mental health services."*

LO'C asked if that meant salaries would be lowered or if it would come from administrative costs as well. *Laura Thomas*, AIDS Office, said it would include both. *Russ Zellers* asked if the motion was to adjust the reimbursement cap or re-negotiate the reimbursement rate. The Council agreed that the intention of the motion was to adjust the reimbursement cap.

The motion to amend the amendment passed, the vote was 20 yes, 6 no. [7]
The amended amendment passed, the vote was 21 yes, 5 no. [8]
The amended motion passed, the vote was 25 yes, 1 no. [9]

Implementation issues: Drop-in centers; After hours; Cap rates for Medi-Cal.

4. **SUBSTANCE ABUSE**

PROPOSED MOTION:
Programs:
- **Adopt Substance Abuse Task Force recommendations.**

TC said the task force had consensus that long and short term residential care should be combined into variable length stays and to cap the length of stay as a way to reduce funding. There was also agreement to combine funding streams and integrate substance abuse with housing and other services. *LO'C* noted there were differing views of harm reduction at the task force meeting, and that having flexibility in determining length of stay for clients is an advantage. *DJ* said there was a meeting in the AIDS Office of people who worked in mental health and substance abuse about harm reduction. There are harm reduction programs that are funded with CARE dollars but they are not necessarily in the substance abuse category. The goal is to have substance abuse services start providing harm reduction services which, other than methadone, is not currently being done. *LO'C* said the length of stay in the residential portion can be shortened, but should not have a 6 month cap for everyone. Some clients need satellite housing after their residential stay. *Michelle Dixon* asked what it meant to redirect dollars to a residential harm reduction model, and where that money would come from. *DJ* said the approach to abstinence based substance abuse programs is changing, and the residential facilities are changing as a consequence. This proposal is meant to be an incentive for providers to continue in the direction of incorporating harm reduction in their services. *TC* said that if there is level funding it would involve adapting an existing program rather than creating a new program. *BC* said, in the Treatment on Demand Council meeting, providers recognized the language of harm reduction which is to reach people where they are. Detox is part of the harm reduction process.
- *BVB offered an amendment "to strike the proposal to redirect some dollars to a residential harm reduction model from a level funding scenario."*

DJ spoke against the amendment because there have been many examples of providers changing services to meet the changing epidemic without new money. The introduction of harm reduction theory to substance abuse is a big change but the Council should encourage providers who are ready and able to do it to use this model and it does not take additional money to do that. *KW* said the Council should not place their values on how programs should work, it may be that some programs work better without harm reduction. *TC* said the language is intended to include harm reduction within all service categories not in all programs. The intent is to make those services more accessible to active users. The community forums showed that services are not very accessible to people who are actively using. The model in the past has been based on abstinence but that is beginning to change and the Council should support that change. *BC* said the harm reduction model is important to incorporate in substance abuse programs. *LO'C* said that even in abstinence based programs harm reduction is starting to play a role.

The amendment was restated *"To strike the equal sign from the level funding scenario in the proposal to redirect some dollars to a residential harm reduction model."*

The restated amendment passed, the vote was 22 yes, 3 no. [10]
The amended motion passed unanimously. [11]

PROPOSED MOTION:
Reductions:
- **Cut under-utilization; limit length of stay in residential programs; cut after care.**
- **Hold harmless new programs.**
- **Don't cut outpatient services.**

JN asked why "after care" was being cut.
- *LO'C offered an amendment "to strike 'cut after care' from the Reductions."*

The idea in the task force meeting was that through linkages "after care" could be covered in other services, but it's a mistake to completely cut it because it's the portion of residential care that some clients need. *TC* said the recommendation to "cut after care" does not mean eliminate it, but to take proportional cuts from that area first in a decreased funding scenario. *Celinda Cantu*, AIDS Office Program Manager, explained "after care" as the means by which clients of a service keep in touch after they have finished using the service. It is the second or third phase of a service rather than the primary phase. *LO* asked what the relationship of

"after care" is to outpatient services. *Celinda* said the funding for these services is not done with CARE dollars. *Laura Thomas* said that the motion as it stands means that "after care" will be cut and then other services will be cut proportionally; with the amendment "after care" will be cut proportionally along with the other services.
The amendment passed unanimously. [12]

DB said that his understanding from the task force meeting was not that there was going to be a limit on the length of stay in residential programs but that fewer people would stay beyond six months. *GG* pointed out that there was no "hold harmless" language in the Reductions unlike the previous categories. The Council agreed to add "hold harmless new services" to the Reductions as a typo. *KW* asked if there was consensus in the task force about limiting length of stay in residential programs because it reads now as though there is a definite cap on the number of days a client can stay in residential programs.
- *DB offered an amendment to strike "limit length of stay" from the Reductions, and replace it with "establish variable and limited rates of reimbursement for" residential programs.*

There was no second to the amendment. *JC* said there was acknowledgment in the task force meeting that some individuals are kept in residential treatment longer than necessary for treatment of their substance use problems because of the housing crisis in San Francisco, and while the Council is sympathetic to that, housing someone in that situation is far more expensive than living independently, even in San Francisco. It would be more cost effective to move that person to the Housing services, and open up the treatment slot to someone in need of it. *BC* called the question. *BVB* asked if "don't cut outpatient services" was included in the Reductions motion.
The proposed motion was restated "to cut under-utilization; limit length of stay in residential programs." (Assumes new services are held harmless)
The restated motion was defeated, the vote was 5 yes, 18 no, and 1 abstention. [13]

BVB suggested restating the motion by listing the proposed reductions in order of priority as follows: "to hold harmless new programs; hold harmless outpatient services; cut under-utilization; cut other programs proportionally." *LO'C* spoke against the restated motion because long term residential is the only area that can afford to take cuts. The Council agreed to the restated motion.
The restated amended motion passed, the vote was 21 yes, 3 no, and one abstention. [14]

Implementation issues: Length of stay assessment; need for housing; work with contractors to adopt harm reduction principles.

5. **CASE MANAGEMENT**
PROPOSED MOTION:
Programs:
- **Adopt Case Management Task Force recommendations.**

TC said the overall theme of the recommendations is integration and reaching out to under-served populations.
- *KW moved to strike the words "groups which lost services under the last RFP." from the proposal in the Case Management spread sheet sub-category that reads "Increase services for any groups which lost services under the last RFP.", and replace them with "populations which are currently under-served."*

BC spoke for the motion because the people who are under-served are the clients currently being served. *FC* echoed that statement.
The amendment to the motion passed unanimously. [15]
The amended motion passed unanimously. [16]

PROPOSED MOTION:
Reductions:
- **Proportional cuts across all sub-categories.**
- **Hold harmless programs newly funded in FY 98-99.**

TC reminded the Council that proportional cuts from Case Management would come from about half the total funds for the category because the rest is being held harmless.
The motion as stated passed, the vote was 21 yes, and 3 no. [17]

6. **FOOD**
PROPOSED MOTION:
Programs:
- **Adopt task force recommendations.**

• *KB moved to amend the proposal to include food services in the integrated service models as appropriate. Michelle Dixon* said there is a reason Food Solicitation was separated from Meal Delivery that might be affected by this motion. *SO* asked if the amendment was to include this entire category into integrated services. *DJ* said it was where appropriate. *DB* spoke against the amendment because the whole issue of integrated services is an implementation issue and should be addressed after the prioritization is done. *TL* asked if clients could only access this service through an integrated service model. *KB* said a part of the integrated service system should have food as a component but not all food service would be in the integrated system. For example, the mobile outreach services would include some food bags. *TC* spoke in favor of the amendment. Food can be included in an integrated system effectively; it can be used as an incentive, or to support adherence to medications, or as an outreach tool. It's a natural inclusion in the integrated system. *JN* spoke in favor of the amendment because it would be consistent with the direction the Council has been going with integrated services during the prioritization process. *SO* asked if this amendment meant funds would be shifted. *DJ* said that was an implementation question but that the amendment did not necessarily mean funds would be shifted. The existing food service providers could be asked to enter into collaboration with an organization that provided integrated services.
The amendment to the motion passed, the vote was 20 yes, and 3 no. [18]

• *AM proposed an amendment "to strike the proposal to combine Food Solicitation with the Food Bank /Meal Delivery sub-category* (on the Food spread sheet) *and let the grantee make that decision."*
JN asked why Food Solicitation was a separate sub-category and not included with Food Bank and Meal Deliver. *Michelle Dixon* said there were two reasons. One has to do with the specific food requirements of people with HIV. The other has to do with providers being able to move their service from one category to another. *LO* said the question of creating and eliminating sub-categories needs to be addressed. He asked why Food Solicitation should be combined with Food Bank and Meal Delivery if the service is to be retained. *TC* spoke against the amendment because the recommendation was made by someone from the Food Bank, in the interest of consolidation of contracts, which is in keeping with the Council's intent of consolidation where it's appropriate. The discussion of how the categories get set up needs to be held at another time.
The proposed amendment to the motion failed, the vote was 13 yes, 8 no, and 2 abstentions. [19]

The motion as first amended passed, the vote was 19 yes, 4 no. [20]

PROPOSED MOTION:
Reductions:
• **Cut under-utilization first, then cut proportionally across all sub-categories.**

TC pointed out that this included nutritional counseling.
The motion as stated passed, the vote was 21 yes, and 1 abstention. [21]

Implementation issues: What is included in integrated services.

7. **OTHER SUPPORT SERVICES**
PROPOSED MOTION:
Programs:
• **Adopt Task Force recommendations**

• *TC proposed an amendment "to strike funding $180,000 to REGGIE for the purchase of equipment for participating agencies under a level funding scenario and to put those funds toward technical assistance."*
KW asked if funding for REGGIE comes from other sources as well. [The DPH has secured in-kind software donations from Mircosoft.]
• *NN proposed an amendment to the amendment "to take $90,000 from REGGIE's funding for the purchase of equipment, and apply it, under Program Support, toward technical assistance for CBOs and training for providers."*
KW spoke in favor of the proposed amendment to the amendment. *LO'C* spoke against the proposed amendment to the amendment, she liked the idea of giving money to technical assistance, but not leaving $90,000 for REGGIE to buy equipment. *TC* spoke against the motion for the same reason.
The amendment to the amendment failed, the vote was 10 yes, 10 no, and 1 abstention. [22]

DB asked what the funds for REGGIE would have been spent on, and what Training and Education is. *TC* said Training and Education is training for treatment advocates, and that REGGIE funds would go toward the purchase of equipment. *DB* said it seems that REGGIE keeps getting funded each year even when the Council votes not to fund it. *DJ* said during the prioritization last year the Council decided to fund REGGIE after the prioritization process. *DB* asked what kinds of things the funds would pay for. *TC* said it would pay for hardware for providers to hook up to the system. It's a good use for unexpended funds. *LO* spoke in favor of the amendment in hopes that more clients will benefit from technical assistance than from REGGIE.

The amendment was restated "*to cut $180,000 from REGGIE and to put those funds toward technical assistance.*"
The restated amendment to the motion passed, the vote was 18 yes, 1 no, and 2 abstentions. [23]

SO asked how, in a level funding scenario, some of the proposed strategies that seem to provide increased services can be accomplished without increased funding. *TC* said that in some cases where a proposal requests increased access and flexibility it may not require additional funds. *SO* said that, for example under Adoption/Foster Care, the recommendation for better services for adolescent placement in foster care sounds as if it requires increased funds. *DJ* said it did not necessarily mean an increase in funding. The Council can go to the provider and voice these concerns and ask them to do a better job of providing services. Then the provider can assess the recommendation and respond with what they think they can and cannot do. *SO* asked if there currently is a van pool that's funded. He said he understands how some of these recommendations can be accomplished with increased funding but not under level funding. *DJ* said that these are areas where the Council would like to see the providers doing a better job and will have to work with them to see what can be done. *LO'C* asked if under Direct Financial Emergency Assistance the recommendation for "decentralized access" meant that there will be more people doing it. *TC* said it means that people can access emergency assistance at more than one point.
The amended motion passed, the vote was 20 yes, and 1 abstention. [24]

DJ asked if it was necessary to take up the Increased Funding scenario to move forward with the grant proposal. *Laura Thomas* said it was not necessary. In the grant the AIDS Office will ask for an amount that will cover all the increased funding recommendations. The Council will have to prioritize increased funding, but not tonight.

PROPOSED MOTION:
Reductions:
- **Cut proportionally across all service categories.**
- **Cuts will be applied first within sub-categories where funds were left unexpended.**
- **Cut REGGIE from Program Support.**
- **Hold harmless Planning Council Support.**

The motion as stated passed unanimously. [25]

Implementation issues: How sub-categories are set up and what goes with them.

II. **Adjournment:** 9:15 PM

8/31/98 HIV Services Planning Council Meeting **1999-2000 CARE Prioritization**

DRAFT

P=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence; **Y**=Yes; **N**=No; **B**=Abstain

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Kirsten Balano	P	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Marianna Balquiedra	A																								
Dorothy Bartolomucci	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	B				
Donald Bliss	P	Y	Y	N	N	Y	N	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	B	B	B	Y
Jeff Byers	P	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	B	Y	Y	Y	Y								
Virginia Cafaro	P			N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
Tom Calvanese	P	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	N	Y	Y	Y	N	Y	N	Y	Y	N	Y	Y	Y
William Carter	A																								
Bart Casimir	P	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Veronika Cauley	E	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y
Fernando Chavez	P	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
John Conley	P	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
Mark Dunlop	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y											
Mariam Farooq	A																								
Gene Gowdey	P	Y	Y	N	N	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Diane Jones	P	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Susan Karp	A																								
Tony Leone	P	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y
Allen Meyer	P	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	B	Y	Y
Lee Ann Monfredini	P	Y	Y	N	N	Y	Y	Y	Y																
Norm Nickens	P	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Johnnie Norway	P			Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y
Lisa O'Connor	P	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	B	B	Y	Y	Y	Y	B	Y	Y	N	Y	Y	Y
Loras Ojeda	P	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	N	Y	Y	N	Y	Y	Y
Stephen Oxendine	P	Y	Y	N	N	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y	Y
Alissa Riker	A																								
Nilda Rodriquez	P	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y
Matthew Sharp	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y
Thomas Sinelair	E	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Brett VanBensehoten	P	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	B	Y	Y	N	Y	Y	Y
Kelly Wallace	P	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mary Jane Wood	A																								

HIV HEALTH SERVICES PLANNING COUNCIL

September 21, 1998 4:30 - 7:30 PM

AIDS Office, 25 Van Ness, 3rd Floor Conference Room

AGENDA

I.	Call to Order	4:30 PM
II.	Roll Call	4:35 PM
III.	Review of Agenda	4:40 PM
IV.	Review and Approval of Minutes of 8/24 & 8/31	4:45 PM
V.	General Announcements	4:50 PM
VI.	Public Comment	4:55 PM
VII.	Committee Reports	5:10 PM
	A. Membership	
	B. PWA Caucus – Consumer Rights Advocate	
VIII.	Co-chairs Report – Review of Prioritization	6:10 PM
IX.	CAEAR Coalition – Report back from Washington DC	6:30 PM
X.	New Business	7:00 PM
XI.	Adjournment	7:30 PM

Future Meetings:

Sept. 22, 1998 - Membership Committee, 25 Van Ness, 5th Floor Training Rooms, 10:30 AM – 12:30 PM
Sept. 28, 1998 - Planning Council, 25 Van Ness, 3rd Floor Conference Room, 4:30 PM - 7:30 PM

San Francisco Department of Public Health – AIDS Office, 25 Van Ness:

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HIV Health Services Planning Council Minutes of Meeting, September 21, 1998

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I. **Call to order**: 4:35 PM.

II. **Roll Call** [1]

III. **Review of Agenda:**

A. *MS* asked that the Review of Prioritization be moved up on the agenda to take place before 6:00 PM. The Council agreed. *NN* and *JB* did not receive the last Council mailing.

IV. **General Announcements:**

A. *TC* welcomed new members to the Council whose appointments were approved by the Mayor's Office. They are: *Chris Boehm, Julie Charubusapayon, Siddiq Jihad, Jorge Ortiz, Susan Shea, and Eric Whitney.*

B. *TC* said that Carol Gong, the proposed representative from the state Medi-Cal office, has withdrawn her name and submitted Samuel Kaplan, a Medi-Cal consultant, as her replacement. The Council will contact Mr. Kaplan and forward his name to the Membership Committee.

C. *TC* said that *FC* would not be at this meeting due to oral surgery.

D. *TC* distributed two letters to Council members: One, a formal apology from the Council to the Latino/a community for the incident involving *WC* at the Brava Theater forum. The other, a memo from *WC* explaining that he is taking a leave of absence for health reasons. *MJW* pointed out that if *WC* is taking a leave of absence he is not able to vote by proxy. If he is absent due to illness he can vote by proxy.

E. *Michelle Dixon* said that *MF* is in the hospital but looking forward to returning to the Council.

F. *BC* may have to resign from the Council because he got a scholarship for the Masters program in social clinical psychology at New College.

G. *JC* told Council members that on 10/30/98 the annual East Palo Alto candlelight vigil will be held. He will bring flyers for the event to the next Council meeting. He said this is an opportunity to see the face of AIDS from a different perspective.

H. *BVB* said that the Health Initiatives for Youth will be conducting a seminar on epidemiology among HIV positive youth. It will take place at the SF Public Library Latino & Hispanic Community Room, on 10/20/98 from 2:00 to 4:00 PM.

I. *MS* passed out a brochure for the Treatment Education Certification Program. He said the word is not getting out about this program. There is a flyer included regarding a Provider Work Group Meeting on Wednesday, Sept. 30, from 10:00 AM to 12:00 PM at the Asian and Pacific Islander Wellness Center, 730 Polk St. 4th floor. The topic will be Nutrition & Emerging Metabolic Side Effects in HIV/AIDS.

J. *TC* welcomed *MJW* and *VC* back.

V. **Review & Approval of Minutes:**

8/24/98 - The Council approved the minutes. *CB, JB, SJ,* and *MJW* abstained.

8/31/98 - The Council approved the minutes. *MB, CB, JB, VC, SJ, AR,* and *MJW* abstained.

VI. **Public Comment:**

A. Irma Torres, who worked at Lyon-Martin Women's Health Services, told the Council that she was demoted, in August, from a bi-lingual case management position, to that of peer advocate. She has been out on temporary disability since April '98. Her hours were cut from 40 to 32. She requested accommodation for doctors' appointments. Her request was denied and she was told that she needed a note from her doctor saying she could work 40 hours a week without restrictions. She said she was forced to resign in September '98. She thinks she has been discriminated against because of her disability. She asked the CARE Council to look into this matter. She believes that the agency is not living up to its mission statement for treating women with HIV/AIDS. *DJ* said the Council does not have the authority to solve labor disputes, but the concern about the agency's ability to work with people who have disabilities is relevant. She said the Council is in the process of evaluating how new programs such as peer advocacy are going to be implemented and that the specific concerns stated would be addressed within that context. *NN* said that the Human Rights Commission is responsible for enforcing city contracts and the treatment of individuals with disabilities. He said *MB* is available as a resource. *AM* offered to help mediate between the parties. He said the broader question of the Council encouraging contractors to hire people with HIV/AIDS and the consequences of that needs to be looked into as well as training of providers. He suggested the AIDS Office also look at this issue. *NN* offered to set up a meeting with the AIDS Office Program Manager for Lyon-Martin if there are issues *Irma* wants to discuss. *MB* also suggested that *Irma* contact the Human Rights Commission. *LO* suggested the AIDS Legal Referral Panel as a resource. *DB* pointed out the larger issue of evaluation of programs and implementation of new systems and the impact that may have on people working with HIV/AIDS needs to be reviewed.

B. Peter Veilleux, Asst. Program Director, Catholic Charities HIV Direct Services, had two announcements: On 10/1/98 from 4:00 to 6:00 PM Peter Claver Community will celebrate its tenth anniversary. He also distributed a letter and analysis chart regarding funding problems for the Partial Rent Subsidy Program and the Rental Assistance Program.

C. Rich Jenson, Program Director, Derek Silva Community, distributed a letter about funding for their program

D. Luis de la Torre submitted a membership application to the Council. *DJ* said it would be forwarded to the Membership Committee.

E. Seana O'Farrell, of Bay Positives, asked *MS* if their organization could take advantage of the Treatment Education Certification Program, even though they are not CARE funded, since they have an RFP pending. *MS* said they could as soon as the grant is announced.

DJ asked *Laura Thomas* to report to the Council on roll over dollars, and the status of the grant application. *Laura* said the AIDS Office received notification that they got what they requested from the Health Resources and Services Administration (HRSA) for roll-over dollars. The amounts available will be $224,000 for non-ADAP Pharmaceuticals, $850,000 for Mental Health contracts, $200,000 for San Mateo County, and $785,758 for direct emergency financial assistance. She said that changes to the grant categories had been made based on the directives of the Planning Council's prioritization plan and the AIDS Office staff. The grant application will hopefully be mailed this Friday, Sept. 25. The deadline for mailing the grant application is Monday, Sept. 28. *LO* asked about Table 7 that was missing. *Laura* said it was not done yet and that it addresses special populations that HRSA mandates as well as those populations the Council decided to include. It will be ready shortly.

VII. **Co-Chairs Report - Review of Prioritization:**

DJ said the Co-Chairs were proposing to the Council that next week's scheduled meeting be canceled. *LO* asked what had been scheduled for discussion at that meeting. *DJ* said the tentative agenda included a report on Planning Council support, and an evaluation of prioritization. The Council approved the proposal. *DJ* proposed that for one of the October meetings the Council plan a portion of the meeting to acknowledge the work of people who have left the Council in recent months.

DJ distributed the Ryan White CARE Act Title I Chief Elected Official (CEO) Roles and Responsibilities Guide from HRSA. Additional copies are available through *TC* or *Laura Thomas.*

DJ said there would be a half-day Steering Committee retreat in October to formulate plans for next year, including Planning Council support and how to proceed with evaluation and implementation.

TC distributed copies of the revised spread sheets from the prioritization process. He suggested Council members refer to the minutes from 8/31, in conjunction with the spread sheet, for a picture of what was prioritized this year. He also referred to the consensus document that gives a broad picture of the issues the Council wants to address this year. The most important issue, that cuts across all categories, is housing which affects all the services being provided. Three broad areas the Council focused on during prioritization were Integration of Services, Outreach/Information, and Outcomes/Outcome Measures. Within these categories the Council is continuing the process it started last year of making an array of services available to clients, reaching out to a broader number of people, and reviewing the outcomes of these efforts to make sure the Council's recommendations are be implemented. He reviewed the changes made to the spread sheet during prioritization.

- In the Health Care category the name of the sub-category Alternative & Complementary Treatment has been changed to *Complementary Treatment.* The Home Health sub-category was divided into two sub-categories: *Home Based Care,* and *Facility Based Care.*
- In the Mental Health category the name of the sub-category Long and Short Term Psychotherapy has been changed to *Long and Short Term Mental Health Services.*
- In the Housing category: The Residential Hospice sub-category was moved into the new Facility Based Care sub-category of Home Health in the Health Care category. The Support Services: Financial sub-category was combined with the Money Management sub-category in the Other Support Services category. The Practical Support sub-category was combined with Peer Advocacy in the Client Advocacy sub-category of the Other Support Services category.
- In the Case Management category the Peer Advocate Outreach sub-category was moved into the Client Advocacy sub-category of the Other Support Services category.
- In the Food category the Food Solicitation sub-category was combined with the Food Bank and Meal Delivery sub-category.
- In the Other Support Services category the In Home Respite sub-category was moved into the Home Based Care sub-category of the Health Services category.
- In the Substance Abuse category the Residential Long Term Treatment and Residential Short Term Treatment sub-categories were combined into a single *Residential Treatment* sub-category.

The grant proposal to HRSA was for approximately $40 million plus 5% for administrative costs. *TC* asked when the award would be received. *NN* said awards are supposed to be made by 12/1/98, but he cautioned that last year they received the award in February. *Laura Thomas* said that Congress can hold up the award. *NN* said that HRSA is using a new internal process for reviewing applications that should speed up the granting of awards, but this is the first year the new system is in place so that may slow down the process. *BC* asked how detox money gets distributed. *DJ* said it pays for methadone and beds. *BC* said he was thinking about how it could be included in residential care around the harm reduction model. *DJ* said that and similar subjects will be discussed during the evaluation of prioritization.

VIII. **Committee Reports:**

A. Membership

TC announced that *Michael Chesek* has resigned as Chair of the Membership Committee. He apologized for the lack of proper notification for last week's Membership Committee meeting. He said the meeting has been rescheduled for tomorrow and they will address the following issues: The incident at the Brava Theater, the three remaining vacant seats on the Council, the demographics of the Council, and election of Committee Co-Chairs. *DB* asked how Council members were notified of meetings. *TC* said all meetings are listed on the agendas that are mailed to Council members, but that this particular meeting did not have proper notification, which is supposed to be 72 hours for any public meeting, and must be listed in the Government Documents section at the San Francisco Main Public Library. *TC* said there would be an orientation for the new members after they were polled for the best time. There is a video tape of a past orientation for any member who cannot make the scheduled orientation. Before the orientation new members will receive a basic set of documents with information about the Council. *TC* said the Council has an informal mentoring process and that new members are welcome to call him with any questions.

B. PWA Caucus - Consumer Rights Advocate

TL said the Caucus has put together a plan for community forums throughout the year. They hope to do two forums for each community group. The planned forums are: Oct. '98 - Latino/a & Youth; Nov. '98 - African American & Women; Dec. '98 - Native American; Jan. '99 - Asian Pacific Islanders & Tenderloin; Feb. '99 - Gay Men & Latino/a; March '99 - Youth & African American; April '99 - Women & Native American; May '99 - Asian Pacific Islander & Tenderloin. June and July will be left open to accommodate additional forums or make up forums that need to be rescheduled. *VC* requested a forum for the Transgender community. *TL* said it was going to be incorporated into the schedule. *MS* asked how the process will happen due to the ambitious schedule. *TL* said it would be each Council member's responsibility for making one of these forums happen. He said the Caucus will coordinate each forum and contact Council members directly. *BC* said it's important to have meetings in the Tenderloin since many clients are there. *LO* said last year the brunt of the work for the forums fell on the PWA Caucus and that very few Council members were present at the community forums or the task force meetings. The responsibility needs to be shared and Council members need to show up regardless of where the forums are held. *TL* discussed the PWA Caucus contribution to the prioritization process and that they want to continue to push for drop-in centers during the implementation phase. It's important that these centers provide real access to people. He is following up on the issue of HIV medications in county jails. Although this subject is not directly related to CARE funding it is an important issue to pursue. The Caucus wants to formalize their mission statement and bring it to the Council. They are also going to be working on model, grievance procedure language that may be presented to the Council in November. The HIV Consumer Rights Advocate has been hired, her name is *Toni Young* and she is presently looking for an office. Now begins the work of developing a program of advocacy that is effective, serves people living with HIV, helps find solutions to grievances, and tracks the issues so the Council can tell where the problems in the system are. *TC* said that *Toni* is hoping to have an office in the next few weeks. There is a three month start up plan that includes establishment of the office and the basic framework for the program. *Toni* said the process would not be a punitive one but one that is solution oriented. *TC* asked Council members to contact him if they have information about office space that might be appropriate. *TC* and *DJ* thanked the people involved for getting this project to the point it is at.

IX. **CAEAR Coalition - Report back from Washington DC:**

TC reported on his recent attendance of the Cities Advocating for Emergency AIDS Relief (CAEAR) Coalition meeting. This is a coalition of Emergency Relief Areas (EMAs) across the country that do advocacy work in Washington for CARE dollars. This meeting was notable in that the CARE Act is up for re-authorization next year which means that it may be changed or not adopted again. The coalition is working on a strategy to get the Act re-authorized. The other representatives from San Francisco were *Bill Barnes* from the Mayor's Office, Ernest Hopkins and Regina Aragon from the AIDS Foundation. The five main issues that emerged from the meeting were: (1) The formula for funding, based on the number of AIDS cases, and how it's administered. (2) New therapies and technologies, and access to treatment. (3) The integrity of Titles I-V of the CARE Act. People argued both sides of the viability of the Titles. (4) Policy changes at the Federal and State level concerning such issues as HIV reporting and immigration policies. (5) Data gathering means are not meeting the needs of local agencies. The next meeting is scheduled for Dec. '98 in Los Angeles. The plan is to have increased representation from San Francisco. *Toni Young* said that the White House policy office is supporting the eroding of the current formula for funding. *SO* asked if there were reports or minutes from these meetings. *TC* said the participants had asked for a report from the meeting which he will forward to Council members. *JC* asked who the official member representing San Francisco is. *Laura Thomas* said the SF AIDS Foundation is an official member of the CAEAR Coalition. In the past the Mayor's Office has paid dues for the Planning Council membership but is currently not funding travel money. *JC* pointed out that the dues are $4,000 which makes it hard for San Mateo to justify spending that amount since it cannot come from CARE funds so must come from the general fund dollars which means it comes directly from some other service for clients. *NN* said that anyone can become a member but there are only one or two votes allowed each EMA. He said the Dept. of Public Health pays for one membership for the department, that membership could be used to send a Council member but the travel dollars

have to come from some source of funding other than CARE. *TC* said in regards to *JC*'s point it was clear that there was not representation in Washington from smaller EMAs. He said that there are scholarships for people with HIV. The caucus group for the CAEAR Coalition recommended that each EMA who sent more than one representative have at least one member who is HIV positive.

X. **New Business:**
DJ said that in October the Council will be taking nominations for Co-Chair.
BC recommended the Treatment Education Certification Program.
AR announced the next Evaluation Committee meeting: Monday, Sept. 28, at 5:30 PM.
JB requested reinstitution of the Council's correspondence folder.

XI. **Adjournment:** 6:30 PM

The Council meets on the third and fourth Mondays of each month, at the time and place noted above. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For HIV-Positive members requesting excused absences due to illness, contact Tom Calvanese at 621-7712. *Minutes of meetings are tentative until formally approved by the Council.*

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9/21/98

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence

Votes [2-]: **Y**=Yes; **N**=No; **B**=Abstain

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	P											
Marianna Balquiedra	P											
Dorothy Bartolomucci	A											
Donald Bliss	P											
Chris Boehm	P											
Jeff Byers	P											
Virginia Cafaro	A											
Tom Calvanese	P											
William Carter	L											
Bart Casimir	P											
Veronika Cauley	P											
Julie Charubusapayon												
Fernando Chavez	E											
John Conley	P											
Mark Dunlop	A											
Mariam Farooq	E											
Gene Gowdey	A											
Siddiq Jihad	P											
Diane Jones	P											
Tony Leone	P											
Allen Meyer	P											
Leann Monfredini	A											
Norm Nickens	P											
Lisa O'Connor	P											
Loras Ojeda	P											
Jorge Ortiz	P											
Stephan Oxendine	P											
Alissa Riker	P											
Nilda Rodriguez	P											
Matthew Sharp	P											
Susan Shea												
Thomas Sinclair	E											
Brett VanBenschoten	P											
Kelly Wallace	A											
Eric Whitney	P											
Mary Jane Wood	P											

HIV HEALTH SERVICES PLANNING COUNCIL

October 19, 1998

The Agenda of this meeting is missing.

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HIV Health Services Planning Council Minutes of Meeting, October 19, 1998

I. **Call to order**: 4:35 PM.

II. **Roll Call** [1]
TC announced that *CB* appointed him proxy holder to vote on the Membership Committee's recommendation of new members.

III. **Approval of Minutes:** None.

DRAFT

IV. **General Announcements:**

A. *TC* announced that the Housing Committee Report, which was not on the agenda, would follow the break.
B. *TC* passed around a membership list to be updated for the mailing list. *NN* noted that this list included home addresses and phone numbers and should not be circulated to the public.
C. *TC* introduced new Council members Julie Charubusapayon and Susan Shea. *JC* is a pediatric HIV clinical social worker for the UCSF Women and Children's Specialty Program. *SS* is a nurse practitioner in the UCSF AIDS Program.
D. *MS* distributed flyers announcing a provider work group meeting of the Treatment Education Certification Program, entitled Treatment Issues with the Multiply Diagnosed, to be held Friday, Oct. 23, 10 AM to 1 PM, at the Asian & Pacific Islander Wellness Center, 730 Polk St., 4th floor.
E. *JM* distributed flyers, from the State office of AIDS in conjunction with the Federal Dept. of Health and Human Services, Health Resources and Services Administration, for a call-in evaluation of AIDS services and/or local consortium/planning councils.
F. *AM* distributed registration forms, from the Pacific AIDS Education and Training Center, for an HIV Adherence Teleconference in San Francisco, Thursday, November 5, at the Radisson Miyako Hotel, 1625 Post St., San Francisco, from 8:30 Am to 1:00 PM.
G. *KW* announced that John Dean Green, Marin County government coordinator for AIDS services, has resigned. Karen Wupio is acting as his replacement currently.
H. *VC* said she took the Treatment Education Certification Program and found it very informative.
I. *BVB* announced a seminar on Epidemiology among HIV Positive Youth at the SF Main Public Library, in the Latino and Hispanic Community Room, Tuesday, Oct. 20, from 2:00 to 4:00 PM.
J. *LO'C* said that Walden House has made changes based on the Council's prioritization recommendations concerning substance abuse. They have moved all the CARE services to one facility, with a variable length program of three months to one year. The changes seem successful.
K. *TC* distributed flyers for a Latino/a community meeting to discuss AIDS services to be held Wednesday, October 28, 6:30 to 8:30 PM, Brava Theater, 2789 24th St. and a Youth Forum to be held October 29, from 12:00 to 2:00 PM, at Health Initiatives for Youth (HIFY), 1242 Market St., 2nd floor.
L. *MS* announced a forum on lipodystrophy at the Metropolitan Community Church, sponsored by UCSF, this evening from 7:00 to 9:00 PM.

V. **Public Comment:** None.

VI. **Co-Chairs' Report:**
TC announced that *WC*, who has health problems, will try to attend this, or the next, Council meeting.

TC reported on recent meetings of the Joint Planning Councils. These meetings were intended to develop better communication between the various Councils as well as with the Department of Public Health, besides facilitating joint planning. The last meeting discussed the structure and relationships between the Councils and the divisions within the Dept. of Public Health (DPH). The goal is increased integration within the DPH.

TC attended an HIV Prevention Council meeting recently where he invited the Co-Chairs of that Council to come to a CARE Council meeting to discuss what their Council does. They discussed the implementation of this year's prioritization, and how there might be joint implementation of it with the prevention plan that has just been completed, as well as the possibility of joint Request for Proposals (RFP). They discussed the upcoming comprehensive needs assessment and incorporating prevention into that document. The Prevention Council would like to be involved in the community forums that are planned for this year by the CARE Council. The Councils discussed sharing resources on joint projects. There will be a report in November about how these ideas will move forward. *LO'C* asked if the Prevention Council is doing needs assessment currently. *TC* said he doesn't think so. *NN* said that all the planning councils are looking at how the others work so there will be less overlap in the future. *KW* said that there is a difficulty because prevention money cannot be used on people who are already infected. *DJ* said the key to joint efforts are resources brought in by the other planning bodies. *TC* said that was not perceived as a problem by the Prevention Council.

DJ announced that nominations for the Co-Chairs would take place next week, and elections will be held in November. She quoted the bylaw language on Co-Chair elections, and said that last year Council members' votes were recorded in the minutes to meet the requirement of a public record on votes. *LO'C* asked if any of the current Co-Chairs terms continue or if all seats are being voted on. *DJ* said the term for Co-Chair is one year, and that all three positions are eligible for renomination by the Council next month.

DJ announced a Steering Committee retreat at her house that will review the structure of the Council and the organization of their meetings. There will be a report on the retreat at the next Council meeting.

VII. **Special Assistant to the Mayor on AIDS policy issues - update:**
Bill Barnes, Special Assistant to the Mayor on AIDS policy issues, announced that Dick Pabich, AIDS Policy Advisor to the Mayor's Office, has resigned. The mayor has asked him to fill the position for now. He said he's working on issues such as the recent AIDS Summit and problems people are having with the AIDS Drug Assistance Program (ADAP) eligibility expiration. He will act as the liaison with the Mayor's Office for the Council. He mentioned an upcoming conference to be held November 13 on physician assisted dying. He said the Mayor put money in the budget for the Employment Development Unit to assist people who are HIV positive in going back to work. If Council members want to contact him, his phone number is 554-5101; fax number 554-6474; E-mail address Bill_Barnes@ci.sf.ca.us. He mentioned that one million dollars that provided services for youth, including Bay Positives, HIFY, and Walden House are going to be lost in December and that the Mayor's Offices is trying to assure that those services continue. He said, next week, he will discuss progress from the Mayor's AIDS Summit Report.

BVB said he will be making a presentation to the Council on a testing initiative that HIFY will be starting shortly to address the discrepancy between the number of HIV positive youth in care and the number listed the last census document.

VIII. **Membership Committee Report:**
TC announced that *LO* and *BVB* have been named Co-Chairs of the Membership Committee to replace Michael Chesek who has left the Council.

A. Recommendation - Appointment of New Members - VOTE
LO said that on Oct. 14 the Committee reviewed seven applications for membership and is recommending four of those for appointment to the Council. They include:
Laura Carcagno Guzman, a bisexual, HIV-negative, Latina who works as the Outreach and Training Coordinator at AIDS Benefit Counselors. She has previously been recommended by the Council for appointment, and that recommendation has been reaffirmed by the Council.
Darrell Joe, a gay, HIV-positive, Native American who is the Assistant Director of the Native American AIDS Project.
Luis De La Torre, a gay, HIV-positive, bilingual, Latino who is an unaffiliated consumer of CARE funded services.
Raymond Combs, a gay, HIV-positive, Native American who had two years experience on the Contra Costa County Ryan White Planning Council.
MS asked how these additions reflect the required demographics for the Council. *LO* said the Council has been underrepresented in Latinos, Youth and Native Americans. *DJ* said these appointments will address the deficiencies in Latino and Native American populations. *VC* asked if there was a policy for transgender demographics on the Council. *TC* said that was an issue that should be addressed in the next round of appointments. *BVB* said that the Committee is trying to reach out to communities that are underrepresented which now includes hemophiliacs. *NN* asked if the Medi-Cal slot is still vacant. *LO* said it was, and that one of the factors in selecting Laura Guzman as a candidate was her knowledge of financial and health benefits since it has been hard to keep a Medi-Cal representative on the Council. *Bill Barnes* said that the Mayor's Office would prefer to see six names submitted for the three vacant seats. *DJ* said the Council has never operated with the assumption that two names have to be submitted to the Mayor's Office for each available seat. *LO* said that it's difficult to get enough membership applications to meet the criteria that's been established for the Council because the criteria shift as each new member is appointed. He said the Committee is not just looking at demographic, applicants must have additional qualifications to serve on the Council. He said that *Bill Barnes'* application was not recommended because it was not clear to the Committee whether he would be representing the Mayor's Office. One name was deferred because the person works outside San Francisco and there may be a conflict. *Bill Barnes* said that he wants to bring his skills to the Council. *DJ* asked him if he was submitting his application as the Mayor's representative to the Council or as an individual. She pointed out that it would not be in keeping with the Health Resources and Services Administration's (HRSA) guidance to have a voting member on the Council from the Mayor's Office. *Bill Barnes* said that it would be difficult to separate his job from his other qualifications. *TC* noted that the Council was being asked to vote on the Committee's recommendation, not on this issue, and suggested that this discussion be referred to the Membership Committee's meeting in November. *MD* asked if the Council has the right to add a name to the recommendation list if they feel it's appropriate. *BVB* said that, according to the bylaws, nominations must

come through the Membership Committee. *VC* moved that this discussion take place in the Membership Committee. *KW* asked what could be done to recruit new members. *TC* said this issue will be addressed at the upcoming community forums. *Bill Barnes* asked if the next Membership meeting would be open. *LO* said that the Membership Committee meetings are open except for the portion which reviews applications. *MD* said that he thinks *Bill Barnes* is a qualified applicant. *DCB* asked how the Council moves forward with the three open seats. *DJ* said the Council needs to vote on the Committee's recommendation. *JC* asked what the process is after the Committee makes its' recommendation. *LO'C* asked if the Council was voting to approve all four names recommended by the Committee. *TC* said the Council is voting on the recommendation which includes four names. *DJ* urged the Council to follow the recommendation of the Membership Committee. She emphasized that the HRSA guidelines say not to politicize the appointment process. She feels the four applicants are strong candidates. *TC* said that Native American representation on the Council has been missing, the Latino/a community has been underrepresented, and these candidates would rectify those situations if appointed. *NN* moved to call the question.
TC called for a roll call vote to accept the Membership Committee's nominations for Council seats, and to forward their names to the Mayor's Office.
The vote passed with one NO vote. [2]

B. Introduction of Proposed Bylaws Revisions:
LO reviewed the proposed bylaw changes made by the Committee:

ARTICLE III Section 3. The language change would extend the term of office on the Planning Council to two years from the current one year. The purpose of this change is to have a more educated Council. It can take a year to understand the full process the Council goes through, *KW* pointed out that the new language appears to be a two year term without the possibility of re-appointment. *BVB* said that Council members can be re-appointed when their term is up. *KW* said there needs to be language included to clarify that. *TC* said that Council members would need to reapply at the end of their two year term to remain on the Council. *MJW* said that this bylaw change reads as though the Council is imposing term limits. She said language about the re-application process needs to be included if the intent is not to impose term limits. *TC* said there is a bylaws attachment concerning the nominations process that includes details that are not in the bylaws. He said Council members' terms would be based on the date of their original appointment not on re-appointment dates. *JB* said it could prove difficult to make this change. *VC* asked if people who were formerly appointed would be grandfathered into the process. *TC* said he did not think that was the intention of the Committee. *NN* said this change cannot apply until after the effective date of the bylaw change. If a member was appointed to a one year term by the Mayor that term cannot be extended by action of the Council. *DCB* said that the current language says "a minimum of one year" and that his letter of appointment does not state what the term is. He said the change clarifies what the term is, and does not keep people from being renominated.

ARTICLE III Section 4. The language change would delete the election date of Co-Chairs "at the first meeting in January." Currently the Co-Chairs are not being elected in January. *SO* asked when the election would take place and how the change came about. *DJ* said that the change came about because changes in HRSA procedure changed the calendar year. *LO'C* asked if there were flags to let people know when it was time for Co-Chair elections. *SO* said he didn't see evidence of flags in the language of the bylaw. *DJ* said it was an administrative question and that the Membership Committee tracks the election dates and keeps the Council informed. *TC* asked if *SO* was concerned about the proposed change or that there was no language to replace the election date. *SO* said it was the latter. *TC* said the Steering Committee will address this issue and bring a recommendation for clarification of language back to the Council.

ARTICLE V Section 5. This is new and refers to the legal language that holds Council members accountable adopted from the Ethics Committee bylaws. *BVB* said discussion of this item will take place in 30 days. *DCB* said that the language is not grammatically correct. DJ suggested that Council members who have questions about this language contact people on the Membership Committee or attend the next Membership Committee meeting. *NN* said this is the first time the Council has seen this language and there needs to be a time for them to discuss it. *KW* agreed that significant bylaw changes need discussion by the full Council. *DJ* said she did not want keep the Council from discussing the issue but thought it was unfair to ask the Membership Committee to recreate their discussion at this meeting. *TC* said this subject is on the agenda for the next Membership Committee meeting. *DCB* assured Council members that the Committee is prepared to discuss this issue with them. *TC* said there was not consensus on this issue within the Membership Committee.

ARTICLE VI. The new heading includes "MEETING ATTENDANCE" to clarify the circumstances under which termination can currently occur according to the existing bylaw.
TC said that members can get a copy of CEO Rules and Responsibilities (?) by calling him or Eric Sorensen in the AIDS Office.

ARTICLE X. This is a new article to address representation of the Council. Community members expressed concern of representation of the Council in public forums. This language helps define the expectation of the

Council in public settings, it allows members to make the distinction between personal comments and comments that reflect the opinion of the Council. The second paragraph allows that distinction to be made by the Council. *MJW* asked how the 45 day period was arrived at. *LO* said it was intended to define the term "practicable" so that issues of public concern would be addressed within a given time. *BVB* said that 45 days allows for any appropriate Committee meetings and a Council meeting before responding.

ARTICLE XI. This was formerly Article X.

C. New Member Orientation;
LO announced a New Member Orientation on October 24, 12 to 4 PM, at 25 Van Ness, 3rd floor conference room. All Council members are invited to attend. If anyone cannot attend there is a video available. *BVB* encouraged established Council members to attend to foster the unofficial mentoring process of the Council.

TC announced that *Dorothy Bartolomucci* was involved in an auto accident today and will need a ride to next week's Council meeting. *MD* noted that the AIDS Office has taxi vouchers if she cannot find transportation.

IX. **Housing Committee:**
TC read a letter, written by *AR*, being sent to the Mayor's and District Attorney's Offices, on behalf of the Council, opposing the incarceration of homeless people for drunkenness. *NN* asked who the letter is from. *TC* said it is from the Council Co-Chairs. *NN* moved to table the item for one week so it can be included on the next Council agenda. *KW* informed the Council that Marin County has a SPINS (?) grant that will expire in February '99. Some of those funds were used for housing solutions so there will have to be changes made in how they finance housing. *TC* said the Housing Committee is getting information on the distribution of emergency housing vouchers. *LO'C* said providers are unclear on how housing dollars reach them. She asked if there is information available on which providers got awards for housing and integrated services. *MD* said that information is available.

X. **PWA Caucus - Report:**
This item was postponed until next week's Council meeting since *TL* was absent. *TC* noted some projects the Caucus is working on: There are two community forums scheduled for next week (flyers for them were distributed at the beginning of this meeting), as well as two community forums scheduled for each of the months of November and December. The consumer rights advocate will be moving into office space in the Hobart Building, on Market St., near the Montgomery Metro station. They are proposing amendments to the language in the AIDS Office draft monitoring protocol to include people living with HIV on staff and boards of agencies, and peer advocacy. They are working on a uniform grievance procedure form. The Evaluation & Assessment Committee has extended an invitation to the Caucus to work together on the needs assessment. The Caucus is recruiting people living with HIV to be part of the monitoring protocol for the AIDS Office and to participate in the needs assessment both as interviewers and interviewees. The next Caucus meeting will be November 4, from 5:00 to 7:00 PM, at 25 Van Ness, in Rm. 330 B.

XI. **Evaluation and Assessment Committee - Report:**
AR reported that *FC* was elected Co-Chair. They moved the evaluation of the grantee assessment to the Steering Committee for an outside evaluator to be hired. The next meeting will focus on the needs assessment for this year and evaluating the '98 implementation. The next meeting will be November 2, from 5:00 to 7:00 PM, at 25 Van Ness, in Rm. 330B.

XII. **New Business:** None.

XIII. **Adjournment:** 7:05 PM

DRAFT

The Council meets on the third and fourth Mondays of each month, at the time and place noted above. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For HIV-Positive members requesting excused absences due to illness, contact Tom Calvanese at 621-7712. *Minutes of meetings are tentative until formally approved by the Council.*

10/19/98

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence

Votes [2-]: **Y**=Yes; **N**=No; **B**=Abstain

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	P	Y										
Marianna Balquiedra	P	Y										
Dorothy Bartolomucci	A											
Donald Bliss	P	Y										
Chris Boehm	E	Y										
Jeff Byers	P	Y										
Virginia Cafaro	P	Y										
Tom Calvanese	P	Y										
William Carter	L											
Bart Casimir	A											
Veronika Cauley	P	Y										
Julie Charubusapayon	P	Y										
Fernando Chavez	A											
John Conley	P	Y										
Mark Dunlop	P	Y										
Mariam Farooq	A											
Gene Gowdey	P	Y										
Siddiq Jihad	P	Y										
Diane Jones	P	Y										
Tony Leone	A											
Allen Meyer	P	Y										
Leann Monfredini	A											
Norm Nickens	P	N										
Lisa O'Connor	P	Y										
Loras Ojeda	P	Y										
Jorge Ortiz	P											
Stephan Oxendine	P	Y										
Alissa Riker	P	Y										
Nilda Rodriguez	P	Y										
Matthew Sharp	P	Y										
Susan Shea	P	Y										
Thomas Sinclair	A											
Brett VanBenschoten	P	Y										
Kelly Wallace	P	Y										
Eric Whitney	P	Y										
Mary Jane Wood	P	Y										

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10/26/98

HIV HEALTH SERVICES PLANNING COUNCIL

October 26, 1998 4:30 - 7:30 PM

25 Van Ness, 3rd Floor Conference Room

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Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	4:35 PM
III.	General Announcements	4:40 PM
IV.	Public Comment	4:45 PM
V.	Co-chairs' Report	5:00 PM
VI.	Special Assistant to the Mayor on AIDS Policy Issues -- Mayor's AIDS Summit Update	5:15 PM
VII.	Housing Committee - -- Endorsement of Attached Letters to Mayor and D.A. (VOTE)	5:20 PM
VIII.	PWA Caucus - Report	5:30 PM
	BREAK	5:30 PM
IX.	Steering Committee Retreat - Report A. FY 1999 Implementation B. Planning Council Support C. Council Structure / Workplan D. Evaluation of Prioritization Process	5:45 PM
X.	New Business	7:25 PM
XI.	Adjourn	7:30 PM

Future Meetings:

- Saturday, October 24, 1998 – **New Member Orientation**, 25 Van Ness, Suite 330-A, 12:00 PM – 4:00 PM
- Wednesday, October 28, 1998 - **Latino/a Community Outreach and Input Meeting**, Brava Theatre, 2789 24th St., at York, 6:30 PM - 8:30 PM
- Thursday, October 29, 1998 - **Youth Community Outreach and Input Meeting**, Health Initiatives For Youth, 1242 Market St., 2nd Floor, 12:00 Noon - 2:00 PM
- Monday, November 2, 1998 - **Evaluation and Assessment Committee**, 25 Van Ness, Room 330-B, 5:00 PM - 7:00 PM
- Tuesday, Nov. 3, 1998 - **Membership Committee,** 25 Van Ness, Room 330-A, 10:00 AM - 12:00 PM
- Wednesday, Nov. 4, 1998 - **PWA Caucus,** 25 Van Ness, Room 330-B, 5:00 PM - 700 PM
- Thursday, November 5, 1998 - **Housing Committee,** 25 Van Ness, Fifth Floor, Training Room B, 10:00 AM - 12:00 PM
- Monday, Nov. 9, 1998 – **Steering Committee**, 25 Van Ness, 5th Floor Conf. Room, 5:00 -- 7:00 PM
- Monday, Nov. 16, 1998 – **Planning Council**, 25 Van Ness, Room 330-A, 4:30 PM - 7:00 PM
- Monday, Nov. 23, 1998 – **Planning Council**, 25 Van Ness, Room 330-A, 4:30 PM - 7:00 PM

San Francisco Department of Public Health – AIDS Office, 25 Van Ness:

The site is fully accessible, and assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to the Council Members, are available for inspection and copying. For further information, call the Council's staff, 415-554-9136. The closest accessible BART Station is Civic Center Accessible MUNI lines serving this location are: #71 Haight/Noriega, #9 San Bruno, F Line to Market and Van Ness, and Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of Meetings are tentative until formally approved by the Council.*

October 19, 1998

Honorable Willie Brown
Mayor's Office
City Hall, 401 Van Ness Ave
San Francisco, CA

Dear Mayor Brown,

We are writing to urge you to stop the current push to incarcerate homeless persons for such offenses as drinking in public and public drunkeness, charges that were not previously under the domain of the Municipal Court. As a body, the HIV Planning Council is concerned about the many barriers to care that homeless persons with HIV and AIDS already confront, and ask you not to allow pending criminal matters to be added to this list.

It is estimated that at least 40% of persons living with HIV in San Francisco live below the poverty level, with 9% being homeless or marginally housed. It is also estimated that 7-12% of homeless persons are infected with HIV. Treatment providers who serve the multiply diagnosed homeless population must attempt to overcome many issues around distrust, and a perceived atmosphere of police harrassment aggravates this situation. The criminal prosecution of homeless persons for alcohol-related offenses can have dire consequences: their arrest and incarceration often results in the loss of all personal property, including medical records, and in the interruption of treatment.

The jail is a costly and inappropriate place for persons' whose only "crime" is alcoholism. During our last prioritization process, we stressed the need for medical detoxification programs for multiply-diagnosed homeless persons. We hope that you will join us by prioritizing treatment over a criminal justice response.

Thank you for your time and attention.

Sincerely,

October 19, 1998

District Attorney Terence Hallinan
District Attorney's Office
Hall of Justice
850 Bryant Street
San Francisco, CA

Dear District Attorney Hallinan,

We are writing to urge you to stop the current push to prosecute homeless persons for such offenses as drinking in public and public drunkenness, charges that were not previously under the domain of the Municipal Court. As a body, the HIV Planning Council is concerned about the many barriers to care that homeless persons with HIV and AIDS already confront, and ask you not to allow pending criminal matters to be added to this list.

It is estimated that at least 40% of persons living with HIV in San Francisco live below the poverty level, with 9% being homeless or marginally housed. It is also estimated that 7-12% of homeless persons are infected with HIV. Treatment providers who serve the multiply diagnosed homeless population must attempt to overcome many issues around distrust, and a perceived atmosphere of police harassment aggravates this situation. The criminal prosecution of homeless persons for alcohol-related offenses can have dire consequences: their arrest and incarceration often results in the loss of all personal property, including medical records, and in the interruption of treatment.

The jail is a costly and inappropriate place for persons' whose only "crime" is alcoholism. During our last prioritization process, we stressed the need for medical detoxification programs for multiply-diagnosed homeless persons. We hope that you will join us by prioritizing treatment over a criminal justice response.

Thank you for your time and attention.

Sincerely,

PRESS RELEASE

FOR IMMEDIATE RELEASE

For More Information, Contact Tom Calvanese: 415-621-7712
For Details about the Latino/a Community Outreach Meeting,
Contact Nilda Rodriguez: 510-658-6930
For Details About the Youth Community Outreach Meeting,
Contact Chris Boehm: 487-1616

SF HIV HEALTH SERVICES PLANNING COUNCIL
HOLDS COMMUNITY MEETINGS WITH YOUTH, LATINOS/AS

The HIV Health Services Planning Council is mandated by the Ryan White CARE Act to prioritize and allocate the federal funds distributed to the San Francisco Eligible Metropolitan Area (EMA) for the care of persons living with HIV and AIDS. The Council is also required to base its decisions, in part, on the priorities of the HIV-infected communities for whom the services are intended.

The San Francisco EMA includes the counties of San Francisco, San Mateo and Marin. The Council allocated approximately $37 million for fiscal year '98 to fund a variety of services including Health Care, Housing, Mental Health and Substance Abuse Services, Case Management, Food, Peer Advocacy, Direct Emergency Financial Assistance, Child Care, Transportation and others. The Council would like to hear from the community about the way in which those funds were distributed by the Department of Public Health's Office of AIDS, the agency responsible for the implementation of the Council's decisions concerning allocation of CARE resources.

The Council recently completed the planning process which will determine how CARE funds will be distributed in the coming fiscal year (FY '99, beginning March 1, 1999). In order to increase community, and especially consumer involvement in this planning process, the Council held a series of community input meetings during the month of July, including a Latino/a Community Input Meeting and a Youth Community Input Meeting.

That planning process is now completed, a plan for fiscal year '99 (beginning March 1), has been completed, and based on this plan, a grant proposal for supplemental CARE Act funds has been written and submitted in Washington, DC. The Council would like to take this opportunity to discuss its plan for FY '99, to receive suggestions for its implementation, to hear from community members about their priorities for services and to discuss the various ways in which community members can become involved in the Council's work.

There will be a community outreach and input meeting addressing the needs of people living with HIV/AIDS in the Latino/a & Hispanic communities on Wednesday, October 28, from 6:30 PM to 8:30 PM, at Brava Theatre Center, located at 2789 24th Street, at York.

A second community outreach and input meeting will focus on the needs of youth living with HIV/AIDS, and will be held on Thursday, October 29, from 12:00 Noon to 2 PM at Health Initiatives for Youth (HIFY), at 1242 Market St., 2nd Floor.

Refreshments will be served at both of these meetings.

American Sign Language Interpretation, interpretation in a language other than English, and/or childcare are available upon adequate notice. Please call 415-554-9136 for further information about interpretation and/or childcare.

LATINO/A COMMUNITY MEETING

TO DISCUSS HIV/AIDS SERVICES FOR THE LATINO/A COMMUNITY
SPONSORED BY THE SAN FRANCISCO HIV HEALTH SERVICES PLANNING COUNCIL

WEDNESDAY, OCTOBER 28
6:30 TO 8:30 PM

BRAVA THEATRE CENTER
2789 24TH ST @ YORK

- SAN FRANCISCO RECEIVES ABOUT $35 MILLION IN FEDERAL CARE FUNDS FOR PEOPLE LIVING WITH HIV/AIDS...
- WANT TO KNOW MORE ABOUT THE 40-MEMBER COUNCIL THAT DECIDES HOW TO SPEND THAT MONEY?
- WANT TO FIND OUT HOW YOU CAN BE MORE INVOLVED IN THAT PROCESS?
- PLEASE JOIN US FOR A COMMUNITY DISCUSSION ABOUT THE NEEDS OF PEOPLE LIVING WITH HIV/AIDS.
- WE ESPECIALLY WANT TO HEAR FROM PEOPLE LIVING WITH HIV/AIDS ABOUT YOUR NEEDS AND HOW THEY ARE OR ARE NOT BEING MET BY CARE FUNDED SERVICES.
- REFRESHMENTS WILL BE PROVIDED.

IF YOU REQUIRE ASL INTERPRETATION, INTERPRETATION IN A LANGUAGE OTHER THAN ENGLISH AND/OR CHILDCARE, PLEASE CONTACT NILDA RODRIGUEZ AT 510-986-0340-, EXTENSION 307 BEFORE FRIDAY, OCTOBER 23..THANK YOU AND WE HOPE TO SEE YOU THERE!

Youth Forum

Presented by
The HIV Health Services Planning Council

We've Got The Dough.

Where Do You Want It?

This is your chance to tell the planning body that prioritizes YOUR money where you think it should be put. Have your needs as an HIV Positive Youth not been met? We want to hear about it. If your needs have been met, we want to hear that feedback too!

We have planned a YOUTH FORUM to be held on October 29th from 12 pm to 2 pm. We'll provide lunch for just showing up (and participating).

This is an opportunity to find out more about the HIV Health Services Planning Council, and to advocate for yourself and other HIV Positive Youth.

Call Chris @ BAY Positives for more information
415.487.1616

HIV Health Services Planning Council Minutes of Meeting, October 26, 1998

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I. **Call to order**: 4:45 PM.

II. **Roll Call** [1]

III. **Approval of Minutes:** None.

IV. **General Announcements:**

A. *JC* distributed a flyer for the AIDS candlelight march this Friday, in East Palo Alto, being co-sponsored by the San Mateo County AIDS Program and the City of East Palo Alto.

B. *CB* recommended that the Council send a letter of support to the Mayor for his advocating on behalf of more youth involvement in the field of HIV.

C. *DB* announced that Full Circle Community Counseling & Support Services is offering three HIV/AIDS groups: Positive Support, Positive Youth, and Positive Professionals.

D. *Michael Moors* announced that name cards are being made for the Council, and passed around a membership list so Council members could indicate the affiliation they would like printed on their name card. *DJ* asked people to verify that the information on the membership list is accurate.

E. *JAC* said the Pediatric Clinic for UCSF Women's and Children's Specialty Program needs therapists to work with children.

F. *Laura Thomas* introduced Chris Collins, from Representative Nancy Pelosi's office, who wants to make sure there is contact between their office and the Council. His phone number in Washington D.C. is 202-225-4965. *MS* asked what's happening with re-authorization of Ryan White funds. *Chris* said that people want to move toward re-authorization. There is discussion of the formula for Title I; the implication of the Congressional Black Caucus initiative that added targeted money onto the regular Ryan White funds; and the Balanced Budget Act that is reducing caps on discretionary spending. *Laura* also introduced Emma Sanchez, Curtis Moore, and Thi Pham, students in the new Public Health Program at SF State University, who are working in the AIDS Office on community projects. They are reviewing the Five Year Plan and trying to assess if it's meeting the needs of the community. They also may work on the needs assessment over the next six months.

G. *TC* distributed copies of the Health Resources and Services Administration (HRSA) newsletter for September, 1998. The focus of this issue is evaluation. He announced that the agenda mailed to Council members is not accurate: (1) There will be nominations for Co-Chairs of the Council as announced at the last Council meeting. (2) There are possible votes on the Steering Committee Retreat report. (3) The PWA Caucus and break will not take place at the same time. He announced that he has accepted a position at the Tenderloin AIDS Resource Center (TARC) as the Deputy Director of Programs. The job will start November 1.

V. **Public Comment:** None.

VI. **Co-Chairs' Report/Nominations:**

WC announced his recent illness, and reaffirmed his belief that the Co-Chairs should serve a term of one year. He said he would like to step down from his position because it's important that Co-Chairs have the energy deal with the rigors of the position which he is unable to do at this time. In addition, in this political year he would like to be able to back progressive causes without the responsibility of this apolitical position. He would like to remain as an ex-officio (non-voting) member until his term is up in January 1999. He will help his replacement make the transition. He thanked the Council for their support over the last year.

TC thanked *WC* for the work he has done as Co-Chair over the last year. He pointed out the difficulty being a participant in the Council process presents to people living with HIV. He said the Council is a better body thanks to *WC*'s participation as Co-Chair over the last year.

DJ opened the floor to nominations for the three Council Co-Chairs. The elections will take place next month. *LO* said that he and *BVB* will review last year's election process before the nominations come to a vote. *DJ* said the guidelines, according to the bylaws, require that the Co-Chairs be: at least one living with HIV, at least one a person of color, and at least one a woman. *JB* asked if all three seats were up for election. *DJ* said they were.

- *JC* nominated **Veronika Cauley.** *KB* nominated **Tom Calvanese.** *DJ* nominated **Nilda Rodriguez.** *MS* nominated **Diane Jones.** *BC* nominated **Siddiq Jihad**. *DB* nominated **Tony Leone.**

TL said the nominations should remain open until the vote takes place. *TC* noted that the bylaws say to use a voting mechanism determined by the Council, and since there is a mechanism that was used last year it should be reviewed by the Membership Committee and brought back to the Council. *DJ* said there was a ballot last year, however the votes were recorded in the minutes. Each member has three votes. *FC* asked if the three votes of a Council member had to be for three different nominees. *DJ* said they did not. *DB* asked what would happen in

the case that the three top vote-getters did not meet the requirements of the bylaw. *DJ* said that the next top vote-getter would be selected until the bylaw requirement was met.

VII. **Special Assistant to the Mayor on AIDS policy issues - Mayor's AIDS Summit update:**
Bill Barnes, Special Assistant to the Mayor on AIDS policy issues, was not present to discuss progress from the Mayor's AIDS Summit Report.

VIII. **Housing Committee - Endorsement of Attached Letters to Mayor and District Attorney:** (vote)
AR presented, for a vote, the letter she distributed at last week's Council meeting, opposing incarceration of homeless people for drunkenness. The letter would be sent to the Mayor's and District Attorney's Offices, on behalf of the Council, from the Co-Chairs. She is concerned that jail is presented as the only acceptable treatment option for homeless people which leads to the criminalization of homelessness. *MS* asked her to explain the phrase "charges that were not previously under the domain of the municipal court." She said that, in the past, if someone was arrested for drunkenness they were brought to a precinct station or jail and held for three to five hours and released with no pending charges. (*DJ* noted that often drunken people are taken to SF General Hospital.) Now those people stay in jail until they have a court date. *BC* was concerned that the letter offered no solutions to the problem of drunkenness. He would like to see language about treatment-on-demand added to the letter. *MB* asked if there were changes in the code to allow this new procedure. *AR* said the District Attorney's Office has always had the option of prosecuting people, but it has not been their practice. She said there is a need for medical detox in San Francisco that doesn't exist, which leads to people being unable to seek treatment unless it is court mandated, which in tern makes the police officers the primary referral source for treatment. *TL* had mixed feelings between the implied permission giving tone of the letter, and the real problem of not enough substance abuse treatment to meet the needs of the city. He suggested stating that in the letter. *DB* supported adding a reference in the letter to a solution or alternative, and suggested referring to the Mayor's stated support of treatment-on-demand and efforts made in that direction by the city. *TC* said that the letter does suggest solutions of medical treatment and prioritization of treatment over criminal justice response. He did not feel the tone of the letter was one of permission giving, it says the Council stresses treatment over criminalization and urges the Mayor and District Attorney to join in that effort. *BC* said he supported the letter and suggested changing the word "hope" to "want" in the last sentence to make the request stronger. "We want you to join us by prioritizing treatment over criminal justice." *DB* still objected to the wording and thought the phrase "treatment-on-demand" should be included since it is a high priority of the Mayor. *KW* called the question.

DJ called for a roll call vote to forward the letter to the Mayor's and District Attorney's Offices with the proposed change to the last sentence.
The vote passed with 1 NO and 4 ABSTAIN votes. [2]

IX. **PWA Caucus - Report - *TL*:**
- The Caucus is currently sending letters to CARE funded agencies to work with their staffs to develop a model grievance procedure. The Consumer Rights Advocate will do most of the work with the agencies.
- The Caucus is working on the community forums. The Latino/a and Youth forums are scheduled for this week. The African American and Women's forums will be held next month. The Native American and Transgender forums will be held in December. He reminded Council members that they have a responsibility to get involved in some of the community forum meetings and said they could contact *NR* or himself.
- The Caucus is developing a work plan for 1999, and they are developing a performance evaluation for the Consumer Rights Advocate.

NN asked for clarification on the letter being sent to agencies regarding grievance procedure. *TL* said the Caucus is looking for an opportunity allow the Consumer Rights Advocate to meet with agency staffs and tell them about the advocate program and how grievances will be handled. *NN* said if the letter is strictly informational it does not need the Council's approval. *LO'C* noted that the Youth forum will be held at Health Initiatives For Youth (HIFY), 1242 Market St., 2nd floor. *TC* noted that the Consumer Rights Advocate office will be in the Hobart Building, on Market St., near the Montgomery Metro station. The AIDS Legal Referral Panel (ALRP) is located in the same building, which is convenient for referral of legal questions that don't come under the purview of the advocacy program. *NN* asked for policy governing the grievance procedure when it is ready. *TC* said the draft was reviewed today and would be distributed when it's done. *TL* noted that the consumer rights grievance procedure was not intended to replace internal grievance procedures, but to supplement them. Agencies should try to resolve complaints internally if possible.

X. **Steering Committee Retreat - Report:**
DJ said the focus of the retreat was on the relationship between the Council and the AIDS Office. Attendees included *TC, DJ, LO, NR, DB,* and *KB* from the Council, as well as *Michelle Dixon, Laura Thomas, Russ Zeller,* and *Norm Nickens* from the AIDS Office.

A. Fiscal Year 1999 Implementation - *DJ*:
A large part of the discussion involved how to evaluate and implement the work of the last year. It was agreed that this is a multi-year process. The HRSA newsletter addresses the question of how to measure success through evaluation and points out that this is a nationwide debate. Implementation of FY '99 is occurring

simultaneously with the evaluation of FY '98-'99 prioritization and the implementation of the integrated serviee model. They diseussed how the AIDS Offiee adapts a model that has historieally been based on eontraet monitoring: (1) to get qualitative evaluation data on whether individual contracts are sueeessful in achieving their goals: (2) to reaeh the target populations; (3) to assess whether the quality of the serviee is appropriate; (4) to determine what the markers are for those points of evaluation. A task foree was set up to develop outeome measures for substanee abuse that are being used, but they don't exist in all the serviee eategories. The organization of the work being done is in two parts: (1) The evaluation of FY '98 implementation. One aspeet of that will be the regular AIDS Office monitoring of eontraets. They will put together review teams which Counеil members will be asked to be on. The other aspeet is the ongoing needs assessment of how the HIV serviee delivery model is and is not meeting the needs of targeted populations. There will be a task foree from the Council and the AIDS Offiee to develop needs assessment with assistanee from other planning bodies. The AIDS Edueation and Training Center (AETC) has diseussed assessing the needs regarding providers. *NN* said that General Fund dollars are available speeifieally for baek to work assessment. *DJ* eireulated a sign-up sheet for Counеil members who want to be part of, either the Evaluation Committee Task Foree, or the Grantee Assessment Task Foree whieh will determine implementation of an assessment of the Department of Publie Health's HIV Serviees seetion that is required by HRSA. *TC* is gathering information from other Eligible Metropolitan Areas (EMA) on how they went about doing this proeess. *MS* asked how mueh work would be required to be on one of these task forees. *TC* said the task forees will develop the seope of these initiatives, but the actual work of implementing them will be eontraeted out. (2) The implementation plan for FY '99-2000 will be produeed by the AIDS Offiee ineluding objeetives, activities, and a timeline in November. The Counеil may be called on to examine the proioritization plan again as this proeess goes on.

B. Planning Counеil Support - *TC*:
TC will phase out of the Projeet Manager position during the month of November. A job description will be sent out. Six months ago the Counеil asked *TC* to: (1) establish a proeess for eontraeting Counеil staff support; (2) make sure that staff supported the prioritization proeess, the analysis of data, the needs assessment, and the establishment of the Consumer Rights Advoeaey Program; (3) develop a job deseription for a permanent staff eoordinator, and eonduet the hiring proeess for that position. What will be in plaee when *TC* leaves the position will be: (1) elerieal support staff; (2) a staff eoordinator; (3) an HIV eonsumer rights advoeate operating a stand alone program; (4) outside eontraetors working on the needs and grantee assessments. What still needs to be done is to (1) delineate the roles of the staff eoordinator and the Co-Chairs, with an emphasis on eoordination and communication; (2) elarify the support provided by the internal support staff, and that provided by the AIDS Office. *TC* reeommended the Steering Committee investigates developing individual eontraets for eaeh of these positions sinee the Counеil is now paying 9% above their support serviee eosts to have the Support Center for Nonprofit Management (SCNPM) write eheeks for those serviees. The total budget for Planning Counеil support for FY '98-'99 is $250,000: with $40,000 budgeted for elerical/logistie support, $35,000 for teehnieal assistanee/eonsultation, $100,000 for data eolleetion/analysis, and $75,000 for the HIV Consumer Rights Advoeaey projeet. To date, the Counеil has spent $43,822 on support serviees. The food budget will have to be expanded if the Counеil is going to meet its eommitment to provide food for eommunity imput, HIV Caueus, and Counеil meetings. *MJW* elarified that the indirect costs for the SCNPM will amount to 9% of what the Counеil spends, not 9% of the total budget. *TC* calculated that the remaining funds should eover the eosts for this year and that a similar budget should cover the eosts for next year with some modifieation of where money gets spent.

KW asked if there was a job description for the staff support person. *TC* said the job description is being worked on now, the staff coordinator will make sure eommunication between eommittees and the Council takes plaee. They will take their direction from the Counеil, the Co-Chairs, and the Committees. It will be a coordination and communieations managemeni position rather than a policy position. *KW* asked if the staff eoordinator will monitor contraets that are arranged by the Counеil. *TC* said they would, under the direction of the appropriate Committee. Oversight of responsibility for these positions has been established. The Consumer Rights Advocate will make monthly reports to the HIV Caueus and will be programatieally evaluated by the Steering Committee. The Evaluation Task Force for the needs assessment will give direetion for the staff support. *KW* said he was disappointed that a consumer was not hired as the Consumer Rights Advocate sinee it was his understanding that was the Council's intention. *TC* said the Consumer Rights Advoeacy Program will include a number of peer advocates who are HIV positive to work with elients. *LO'C* asked in what order the proeess of hiring support staff for the Counеil would happen. *DJ* said the top priority is the job deseription whieh *TC* is working on, and then finding a replaeement for him that will happen in the Steering Committee who will then present their reeommendation to the Counеil. The question of whether to eontinue using the SCNPM for some projeets will be looked at by the Steering Committee as well. *LO'C* asked if another Council member could fill the job *TC* has been doing. *TC* said it's important to keep the role of Council member distinet from that of staff support and does not reeommend that a Counеil member tries to take on the position of staff support. The staff support person needs to have a level of objectivity that would be diffieult to maintain being a Counеil member. He said it would be good for that person to have had experienee with the Counеil. *JB* asked when the support budget for next year will be determined. *DJ* said the

budget will be brought to the Steering Committee and then to the Council, hopefully before the next FY starts. *FC* asked when the staff support job description will be presented to the Council. *TC* encouraged members to go to the next Steering Committee meeting and authorize that body to make a decision quickly. *MS* pointed out that there was only one application for the Consumer Rights Advocate program. He supported having the Steering Committee create the job description for the staff coordinator. *TL* said that the PWA Caucus felt some pressure to fill the Consumer Rights Advocate position after sending the Request for Proposals (RFP) out twice. *DB* asked how the organizational infrastructure for the new positions would be developed. *DJ* said the Steering Committee is in charge of the support staff. *DB* said he did not see procedural policy in place. *TC* said this is a new position and there are few policies in place yet. *DB* said he would have a hard time voting on this issue without more written definition. *TL* said that there is a written definition of the Consumer Rights Advocate Program. *DJ* said copies of contracts were available. *DB* said the issue is not about contracts but about monitoring and evaluating. *TC* said those subjects are included in existing contracts. *DB* asked who the Consumer Rights Advocate reports to. *TC* said the Advocate reports to the HIV Caucus monthly on the content of the work being done, and the quality of their work is being assessed by the Steering Committee. *DJ* pointed out that the Council is in transition between the start-up and permanent phases of these positions. The direction the Council is headed will address the questions of how those positions function.

C. Council Structure/Workplan -*DJ*:
A Proposed Committee Structure and Annual Workplan from the Steering Committee Retreat was distributed. Last year the Council broke into workgroups that met in August allowing the public and providers to participate in the prioritization process. The proposal suggests five workgroups: Housing, Health Care, Mental Health, Substance Abuse and Other Support Services, Counties that would meet April through August giving more time to produce recommendations to the Council for prioritization. The Steering Committee, Membership Committee, and PWA Caucus would meet year-round. The Implementation & Evaluation Committee would meet September to March. The proposal suggests Committee, Caucus, and Workgroup meetings take place the first week of the month, followed by the Steering Committee meeting the second week of the month, and **one** full Council meeting the fourth week of the month. It would be necessary to revise the bylaw requirement on attendance if this proposal is adopted. *DJ* said that discussion of this proposal focused on the fact that Council members come to the current two Council meetings per month, but most do not attend committee meetings. The Steering Committee feels that if more Council members are involved in the work done at committee level, not as much time will need to be spent in Council meetings. The proposal requires Council members to attend one Council meeting and one committee meeting each month, and a, yet to be determined, number of community forums each quarter. This would shift the focus of the decision making process more to the Committees. It would require using the support staff to write reports of committee meetings so that Council members will have a better idea of what happened during the meeting.

KW thinks it's a good idea, but asked that the Council be kept informed of upcoming issues for debate at committee meetings so that those conversations do not have to be recreated at Council meetings. *VC* thought it would be good to have more people involved at the committee level, but had some concerns about only one Council meeting per month. *JB* said he supported the proposal and pointed out that this Council is the only one, of six he goes to, that meets more than once a month on a regular basis. He thought the committee requirement was a good one. *TL* thought mandatory committee membership was a good idea. He would like to see a written reference to the contribution the PWA Caucus makes to the prioritization process. *Laura Thomas* was concerned that the planning function of the Council is no longer reflected in the committee structure. She suggested adding some planning component before prioritization. *MS* liked the proposal, and pointed out the need to develop an attendance monitoring system. *MJW* thought committee membership was already mandatory, and was concerned that if it wasn't being counted toward attendance now, what would make it count in the future. She related the history of the Council that originally met twice a week for four hours each night for six months, then once a week with liberal attendance requirements, then three times a month with members encouraged to attend committee meetings. She feels the pressure to have more committee meetings and fewer Council meetings is not going to be a solution, but that committee attendance is a problem. *DJ* said the problem is that Committee participation has never been enforced. She said the Steering Committee is looking for a structure that makes the Council more effective. She asked if Council members think more work needs to be done at the Council level or if more can be done at the committee level. *LO'C* thought the proposal was a good one. *FC* said he supports more members participating on the Committees, but there need to be good minutes from committee meetings as well as accurate agenda calendars of upcoming committee meeting dates for this proposal to work. *TC* said the structure will only work if there is good communication from the Committees to the Council both pre and post meeting. *CB* thought the proposal was a good idea. *DB* said it's a sign of a healthy organization when discussion comes back to the Council to be recreated. He supports the work groups and would like to see attendance at community forums become mandatory. He suggested committees all meet at the same time, on the same night, so it would be easier for people to arrange to be there. *KB* pointed out that committees tend to disband and it's hard to keep track of attendance. She said the proposal reflects what the needs of the Council are now and that those needs may change in the future She asked if the planning function of the Implementation &

Evaluation Committee can be separated. She thinks the Council has become a more trusting group and that the work done at committee level is more accepted by the Council. *BC* thought there was a communication problem that may be addressed by having a staff person at all meetings. *LO* said the Membership Committee was looking at attendance records currently. He supports increasing the number of Council meeting during the prioritization process. *TL* suggested sending out agendas and written reports from committee meetings. *JAC* asked for a point person to contact if she can't make a meeting. *DJ* said there will need to be a bylaw revision. The Steering Committee will present a revised proposal to the Council next month. *JB* asked if the proposal will be voted on. *DJ* said it would.

DJ asked if the Council wanted to do a formal evaluation of prioritization by discussion or by form. The Council agreed on a discussion that will take place at an upcoming meeting. She mentioned having a social event next month to thank former Council members for their involvement.

XI. **New Business:** None.

XII. **Adjournment:** 7:35 PM

The Council meets on the third and fourth Mondays of each month, at the time and place noted above. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For HIV-Positive members requesting excused absences due to illness, contact Tom Calvanese at 621-7712. *Minutes of meetings are tentative until formally approved by the Council.*

DRAFT

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-]: **Y**=Yes; **N**=No; **B**=Abstain

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	P	Y										
Marianna Balquiedra	P	N										
Dorothy Bartolomucci	A											
Donald C. Bliss	P	B										
Chris Boehm	P	Y										
Jeff Byers	P	B										
Virginia Cafaro	A											
Tom Calvanese	P	Y										
William Carter	P	B										
Bart Casimir	P	Y										
Veronika Cauley	P	Y										
Julie A. Charubusapayon	P	Y										
Fernando Chavez	P	Y										
John Conley	P	B										
Mark Dunlop	A											
Mariam Farooq	A											
Gene Gowdey	P	Y										
Siddiq Jihad	P	Y										
Diane Jones	P	Y										
Tony Leone	P	Y										
Allen Meyer	P	Y										
Leann Monfredini	A											
Norm Nickens	P	Y										
Lisa O'Connor	P	Y										
Loras Ojeda	P	Y										
Jorge Ortiz	P	Y										
Stephan Oxendine	A											
Alissa Riker	P	Y										
Nilda Rodriguez	A											
Matthew Sharp	P	Y										
Susan Shea	P	Y										
Thomas Sinclair	A											
Brett VanBenschoten	A											
Kelly Wallace	P	Y										
Eric Whitney	P	Y										
Mary Jane Wood	P	Y										

DRAFT

HIV HEALTH SERVICES PLANNING COUNCIL

November 16, 1998 4:30 - 7:30 PM

25 Van Ness, 3rd Floor Conference Room

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Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	4:35 PM
III.	Review and Approval of Agenda	4:40 PM
IV.	Review and Approval of Minutes from 9/21, 10/19 and 10/26	4:45 PM
V.	General Announcements	4:50 PM
VI.	Public Comment	4:55 PM
VII.	Committee Reports	5:00 PM
	A. Membership Committee - Co-chair Election Process (VOTE - on process)	
	B. PWA Caucus - Notice of Proposed Bylaws revision	
	C. Evaluation Committee	
	D. Housing Committee - Approval of HOPWA Loan Committee representative (VOTE)	
VIII.	Steering Committee - Proposed Organizational Structure (VOTE)	5:45 PM
	BREAK	6:15 PM
IX.	Prioritization Evaluation - facilitated discussion	6:30 PM
X.	New Business	7:25 PM
XI.	Adjourn	7:30 PM

Future Meetings:

Monday, November 23, 1998 - **Planning Council,** 25 Van Ness Ave., Room 330A, 4:30 PM - 7:30 PM
Wednesday, December 2, 1998 - **Membership Committee**, 25 Van Ness Ave., 11:00 AM - 1:00 PM
Wednesday, December 2, 1998 - **PWA Caucus**, 25 Van Ness Ave., 5:00 PM - 7:00 PM
Thursday, December 3, 1998 - **Women's Community Meeting**, Lyon Martin, 1748 Market St. (time TBA)
Monday, December 7, 1998 - **Evaluation Committee**, 25 Van Ness Ave., 5:00 PM - 7:00 PM

San Francisco Department of Public Health – AIDS Office, 25 Van Ness:

The site is fully accessible, and assistive hearing devices and signing are provided upon adequate notice Minutes of meetings and all information distributed to the Council Members, are available for inspection and copying. For further information, call the Council's staff, 415-554-9136. The closest accessible BART Station is Civic Center. Accessible MUNI lines serving this location are: #71 Haight/Noriega, #9 San Bruno, F Line to Market and Van Ness, and Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of Meetings are tentative until formally approved by the Council.*

Proposed Committee Structure (Proposed at Steering Committee Retreat, 10-20-98)

Prioritization Workgroups (Meet April to August)

- Housing Workgroup
- Health Care Workgroup
- Mental Health Workgroup
- Substance Abuse Workgroup
- Other Support Services, Counties Workgroup

These workgroups would function as they did during this year's prioritization, but would begin functioning earlier in the fiscal year, giving them more time to produce recommendations to the Council for prioritization, and would develop mechanism for joint meetings, as appropriate to promote integration of services.

Implementation and Evaluation Committee (Meets September to March)

This Committee would be responsible for producing an implementation plan for the prioritization plan, and then for evaluating both the implementation of that plan, as well as the evaluation of previously established programs, *and other evaluative tasks, as required by HRSA.*

Steering Committee (Standing, meets year-round)

This Committee would be responsible for coordinating the work of the workgroups and committees, Council support staff supervision, addressing bylaws changes, setting agendas for Council meetings, conducting the Grantee Assessment and, with the PWA Caucus, the evaluation of the HIV Consumer Rights Advocacy Program.

Membership Committee (Standing, meets year-round)

This Committee would be responsible for recruiting new members, making recommendations to the Council for appointments, the orientation of new members, review of attendance, and other work related to Council membership.

PWA Caucus (Standing, meets year-round)

This standing Committee of the Council would be responsible for oversight of the Council's progress toward its stated goal of "fully involving People Living With HIV/AIDS in the design, implementation and governance of the system", would participate in the new member orientation, participate in the needs assessment, and evaluation of programs, including the HIV Consumer Rights Advocacy Program, coordinating monthly community outreach and input meetings, and addressing any issues of concern to members who are PLWH/AIDS. *The Caucus is also responsible for ensuring that input from PLWH/AISD is included in the Council's prioritization and allocation plan.*

Note: The Housing Committee will no longer be a standing Committee, but will meet as an Ad Hoc Committee, as needed, from September through April, when the Housing Workgroup will reconvene.

Proposed Meeting Schedule

The Committees, Workgroups, and Caucus would meet monthly, during the first week of the month. (Reflecting the changing nature of the Council's work during the year, the Committee structure would change periodically, as noted above.) The Steering Committee would meet during the second week of the month, and the full Council would meet **once** per month, to focus on deliberations and decisions based on Committee recommendations. Task Forces and Ad Hoc Committees may be convened as needed, to address time - limited issues.

Note: This would make it necessary to revise the bylaws requirement on attendance, possibly to include a requirement for attendance at a certain number of community outreach and input meetings.

HIV HEALTH SERVICES PLANNING COUNCIL
EVALUATION OF FY 1999-2000 PRIORITIZATION PROCESS

Please note that we have placed on the agenda for the meeting of November 16, a discussion to evaluate this year's prioritization process. At our last meeting, it was agreed that this would be more helpful than a written survey, as has been done in the past. Please come prepared to participate in this discussion. We are particularly interested in the participation of new members for whom this may have been the first experience of this type of decisions making process. The following discussion points are intended to provide 'food for thought', and are not intended to limit the discussion, though there is particular interest in these topics.

Discussion Points: For each of the following topics, please consider the following:

1. Did this information, presentation, meeting, or process contribute to my understanding of the decisions I was asked to make? If so, how? If not, why not? How would I change it?
2. Did this information, presentation, meeting, or process contribute to the final product, that is, the prioritization plan produced at the final meetings in August? If so, how? If not, why not? How would I change this?
3. Are there any additional suggestions I would make about how to improve the Council's prioritization and allocation process next year?

Topics:

1. Data: Epidemiology, Utilization
2. Presentations: Housing, Home Health, Transgender Study, Mental Health, Homeless, New Treatments, San Mateo, Marin
3. Community Input Forums: Latino/a, Asian/Pacific Islander, Tenderloin/Homeless, Youth, Native American, African American, Women, AIDS Service Providers
4. AIDS Office Input
5. Service Providers Input
6. Task Forces/Workgroups: Housing, Health Care, Mental Health Services, Substance Abuse Services, Other Support Services, San Mateo County, Marin County
7. Decision Making Content
8. Decision Making Process
9. Participation in review of Supplemental Application to HRSA
10. Implementation/Workplan - transition to implementation after completion of prioritization

HIV Health Services Planning Council - Housing Committee

Report

To: Members, HIV Health Services Planning Council

From: Tom Calvanese, Co-chair, Housing Committee

Date: November 4, 1998

Re: Housing Committee meeting

Attendees: Tom Calvanese - Committee Co-chair; Ali Riker, Council Member; Mark Trotz, Pam Simms, DPH Housing Division, Amy Cunninghus, San Francisco AIDS Foundation Housing Program

Committee Report

Housing Resource Distribution Problems

The Committee discussed the problem of the underutilization of Emergency Housing Vouchers and Shallow rent subsidies included in the programs funded by the AIDS Office as part of the implementation of the Council's FY '98-'99 prioritization plan. The DPH Housing Division presented a proposal to address the problems, with the goal of more efficiently distributing the resources before the end of the fiscal year. The issues identified during meetings with Integrated Service Agencies included the following:

1. 28 day limit on length of stay for emergency vouchers is not sufficient to stabilize clients
2. Agencies "hoarding" allocated vouchers, fearing that they will run out of allocated vouchers
3. Implementation problems at larger collaborations
4. $100 - $300 shallow rent subsidy not sufficient in current rental market
5. Lack of available affordable housing is a barrier to locating housing to subsidize
6. Eligibility criteria requiring disability for subsidies is a barrier to current client population: many are disabled, but do not possess documentation

In an effort to address these concerns, and to facilitate the distribution of housing resources, the DPH housing division recommended the following strategies:

1. Pool housing resources

2. Extend length of stay for emergency vouchers to 90 days

3. Increase subsidy allocation "ceiling" to $400

4. Change criteria for homelessness to include "imminently homeless", in order to include those unable to maintain housing due to paying more than 60% of their income toward rent

5. Allow for individuals to be taken from Housing Wait List when no eligible clients are identified elsewhere

The Committee members expressed concern that programs not "give up on" target population. Committee members supported these changes, with the following considerations:

1. Include money management as part of an overall housing stabilization strategy, to facilitate the establishment of residency

2. Include benefits counseling as part of strategy to assist individuals who are eligible for, but not receiving, disability benefits

3. Increase outreach efforts to identify individuals not currently receiving assistance, and to bring them into care

The Committee agreed that it would be helpful if the Council attended the next meeting of the Integrated Service Agencies, to help clarify some of the changes in housing contained in the Council's '98-'99 prioritization. Tom Calvanese and Ali Riker agreed to attend the next ISA meeting, to be held on November 23, from 3:30 to 5:00 at 25 Van Ness, room 330B.

Future of Housing Committee

Committee members discussed the Proposed Committee Structure and Workplan. It was agreed that we would support the proposal, but that we would like to identify Council members who would represent the Council at other existing housing policy bodies. The Council currently has two seats on the HOPWA Loan Committee. One of these seats is currently held by Tom Calvanese. Ali Riker agreed to serve on the HOPWA Loan Committee as the Council's other representative. The Committee is recommending that the Council approve Ali Riker as its second representative on the HOPWA Loan Committee. The Committee would also like to identify Council members who would be interested in representing the Council at the Supportive Housing Subcommittee of the Comprehensive Housing Affordability Strategy, or CHAS, at the Housing Wait List/HOPWA Subsidy Advisory Committee, and at the Local Board on Homelessness. The Committee also agreed that it would hold ad hoc meetings, as needed, during the months when the Housing Prioritization Workgroup is not meeting (September to April), to address housing concerns relevant to the Council. Council members who would like to be noticed when Ad Hoc Housing Committee meetings are scheduled, should contact either Tom Calvanese or Ali Riker.

HIV Health Services Planning Council

PWA Caucus

25 Van Ness Ave, 5th Floor
San Francisco, CA 94102

November 4, 1998

TO: HIV Health Services Planning Council

FROM: Tony Leone, Co-Chair PWA Caucus Tony Leone

RE: PWA Caucus Report

The question was raised at the last CARE Council meeting by a member about the practice of calling the PWA Caucus just the PWA Caucus and not referring to People Living with HIV as well as People Living with AIDS. There was considerable discussion including the comment that it is after all one disease. The consensus of the PWA Caucus was not to change its name.

In further action the Community Input Forums were tentatively scheduled throughout 1999. We are developing the African-American Forum for November and for December the Women's Forum, Native-American Forum, and the Transgender Forum.

We have developed a Council Bylaws Amendment that establishes the PWA Caucus as a permanent standing Committee of the Council.

We have developed a draft workplan for the PWA Caucus for 1999. The PWA Caucus will vote on this draft at its December 1st meeting.

Annual PWA Caucus elections for Co-Chairs will be held at the December meeting also. Anyone interested should attend.

We continue to work on the implementation of the HIV Consumer Rights Advocate project. We are working on developing a draft Performance Appraisal Tool for submission to the Steering Committee. We are working with the Council Co-Chair to develop a job description.

This summarizes our current efforts. If you have any questions or comments please contact me. Thank you.

Agenda

HIV Health Services Planning Council

PWA Caucus

12/02/98
5:00 PM to 7:00 PM
25 Van Ness Ave.
Room 330A

Agenda for December 2nd Meeting

5:00-5:05 PM	Welcome & Introductions.	Tony Leone.
5:05-5:15 PM	Co-Chair's Report.	Nilda & Tony.
5:15-5:30 PM	HIV Consumer Rights Advocate.	Toni Young.
5:30-5:45 PM	PWA Caucus Co-Chair Elections.	
5:45-6:45 PM	Business.	
	* Community Input Forums.	Tony.
	* Update Caucus Workplan.	Tony.
	* Formalize Mission Statement into Council Bylaws.	
	* Needs Assessment.	Tom & Tony.
6:45-6:50 PM	Agenda Items for next Meeting – January 6, 1999.	Tony Leone.
6:50-7:00 PM	Announcements.	
7:00 PM	Adjournment.	

Next *PWA Caucus* Meeting is

January 6, 1999 -- 5:00 – 7:00 PM

25 Van Ness Ave, Room 330A.

Submitted by,

Tony Leone

Tony Leone
Co-Chair

HIV Health Services Planning Council - PWA Caucus

25 Van Ness Ave, 5th Floor
San Francisco, CA 94102

November 4, 1998

TO: HIV Health Services Planning Council

FROM: Tony Leone, Co-Chair PWA Caucus

RE: Community Outreach and Input Meetings for 1998, 1999

The PWA Caucus has agreed to establish the following TENTATIVE schedule of Community Outreach and Input Meetings for the remainder of 1998 and into 1999 in order to be ready for the next Council Prioritization Process.

1998

October

October 28th, Latino Forum at the Bravo Theater, 24th Street. 6:30-8:30 PM.
- contact: Loras Ojeda

October 29th, Youth Forum at HIFY, 1242 Market Street. 12-2 PM.
- contact: Chris Boehm

November

African-American Forum
- contacts: Steve Oxendine, Siddiq Jihad, Bart Casimir

December

December 3rd, Women's Forum at Lyon-Martin Clinic, 1748 Market Street
- contacts: Lisa O'Connor and Nilda Rodriguez.

Native American Forum - contact: Tom Calvanese.

Transgender Forum - contact: Veronika Cauley

1999

January

Asian-Pacific Islander Forum - contact: Matt Sharp.

Homeless/Tenderloin Forum - contact: Tom Calvanese

February

This process will be re-evaluated before we continue with the tentative schedule of Forums.

HIV Health Services Planning Council

PWA Caucus

25 Van Ness Ave, 5th Floor
San Francisco, CA 94102

November 4, 1998

TO: HIV Health Services Planning Council

FROM: Tony Leone, Co-Chair PWA Caucus

RE: Proposed Amendment to the Council Bylaws

The PWA Caucus has voted to present the following motion to amend the Bylaws to the full Council for action.

MOTION:

To amend Article IV of the Bylaws by adding a new section as follows:

Section 10. The PWA Caucus is a standing committee of the Council which meets regularly and reports regularly to the HIV Health Services Planning Council providing input and advice on all matters pertaining to PLWH/AIDS through the planning, prioritizing, implementing, and evaluating processes of the Council. The duties of the PWA Caucus include:

A) Oversee progress toward goal of "fully involving People Living with HIV/AIDS, PWAs in the design, implementation and governance of the system.
B) Participate in new Council member orientation.
C) Coordinate the efforts of the Council in conducting community meetings, forums, focus groups, panels and other methods for Council input from consumers of CARE-funded services as well as potential consumers.
D) Participate in the development and implementation of Community assessment techniques including consumer satisfaction measurements, focus groups, needs assessment, input from other Community groups, including Service Providers.
E) Provide education about the Council and the PWA Caucus activities to the Community and to specific consumers.
F) Ensure that input is brought into the Prioritization Process in a meaningful way.

HIV Health Services Planning Council
PWA Caucus 1999 Workplan

Goal 1 : Monitor HIV Consumer Rights Advocacy Program (HCRA Program)

Strategies:

1. Assist in development of performance evaluation criteria, and participate in evaluation
2. Monitor progress of project through monthly reports from HCRA
3. Work with HCRA to identify unmet needs, service gaps and unresolved complaints, and make recommendations to Planning Council as appropriate

Goal 2: Enhance PLWH/AIDS inclusion on RFP Review Panels and Monitoring Teams (Council has approved policy of 50% goal for PLWH participation)

Strategies:

1. Recruit, mentor and assist in training HIV+ individuals to serve on RFP Panels and Monitoring Teams.
2. Monitor PLWH/AIDS inclusion on RFP Review Panels and Contract Monitoring Teams

Goal 3: Encourage and monitor progress of hiring and utilization of PLWH/AIDS on contracting agency staff and boards

Strategies:

1. Assist in developing contract incentives to promote this practice
2. Monitor progress through participation in contract monitoring

Goal 4: Coordinate Community Input

Strategies:

1. Schedule community outreach and input meetings in community settings
2. Recruit Council members as lead organizers for each community meeting, coordinate with Council support staff
3. Reevaluate community outreach and input meetings after January
4. Work with Evaluation Committee in development of comprehensive needs assessment

Goal 5: Participate in new member orientation

Strategies:

1. Participate in new member orientation in collaboration with Membership Committee
2. Encourage PWA Caucus members to participate in mentoring of new members

Goal 6: Encourage participation at PWA Caucus meetings by both consumers of CARE funded services, and those eligible, but not currently receiving care

Strategies:

1. Produce monthly press releases noticing meetings as open, and inviting the participation of community members, with the assistance of support staff
2. Provide transportation and/or child care, as needed by PLWH/AIDS who wish to attend, as well as refreshments at meetings

Goal 7: Provide education about the Council and the system of care to the community at large and to consumers of CARE funded services

Strategies:

1. Provide education at Community Outreach and Input Meetings
2. HIV Consumer Rights Advocate to assist in dissemination of information about the system of care
3. Use Complaint/Grievance Forms as source of information about the system of care
4. Provide report to community about changes to the system of care in advance of implementation of changes

HIV Health Services Planning Council - Evaluation Committee

Report

To: Members, HIV Health Services Planning Council

From: Ali Riker, Fernando Chavez, Co-chairs, Evaluation Committee

Date: November 2, 1998

Re: Evaluation Committee meeting

Attendees: Ali Riker, Fernando Chavez - Committee Co-chairs; Jorge Ortiz, Allen Meyer, Eric Whitney, Tom Calvanese - Council Members; Russ Zellers, Billy Pick, Laura Thomas - AIDS Office; Luis De La Torre - Council applicant, Jim Illig - President, HIV Contractor's Association, Representatives from AETC (names?)

Committee Report

Comprehensive Needs Assessment

The Committee discussed the implementation of the Comprehensive Needs Assessment. A Needs Assessment Task Force has been established and the following members have signed up to participate: Tony Leone, Don Bliss, Siddiq Jihad, Bart Casimir, Norm Nickens, Susan Shea, Loras Ojeda, Ali Riker, Eric Whitney, Matt Sharp, Jorge Ortiz, Kirsten Balano, Lisa O'Connor and Tom Calvanese. In the interest of getting started on this rather ambitious project, the Committee has scheduled the first meeting of the Task Force for Thursday, November 12, from 3PM - 5 PM, at 25 Van Ness. Members who signed up to participate in the Needs Assessment Task Force, who are unable to attend this meeting, should contact either Ali Riker, Fernando Chavez, or Laura Thomas to notify them of preferred alternate meeting times.

The Committee reviewed a draft proposal for the Needs Assessment from Laura Thomas in the AIDS Office. Laura will be the AIDS Office Staff member responsible for supporting the Needs Assessment Task Force. At its first meeting, the Task Force will be working out the details of the mechanism for administering the Needs Assessment, including reviewing a draft scope of work, the details of soliciting bids from potential contractors, the hiring process, and will begin to develop a workplan for the project. The Committee also discussed the timeline for the project, agreed upon a tentative budget of $150,000, with the possibility of additional resources to be contributed from the AETC, the DPH Employment Development Unit, and the HIV Prevention Planning Council.

Fiscal Year 1998-1999 Implementation Evaluation

The Committee reviewed materials requested from the AIDS Office at its last meeting, and provided by Russ Zellers from the AIDS Office. These materials included the following: Update on Implementation of FY 98-99 Proposed Priorities and Allocations, FY 97-98 Contracts Put Out-to-Bid or Defunded, FY 98-99 Awards, RFP published January 1998, Alternative Solicitation (August 1998). Russ Zellers provided an orientation to the materials, and the Committee decided that the list of Questions produced at its last meeting would be distributed to Committee members for consideration in preparation for its next meeting, where Committee members would bring questions, comments and recommendations for the implementation of the Council's FY 99-00 prioritization and allocation plan. The Committee will also review the draft implementation plan from the AIDS Office for FY 99-00 at that time.

Discussion of proposed Committee Structure, Workplan and Meeting Schedule

The Committee discussed the Steering Committee's proposed Committee Structure, Workplan and Meeting Schedule. Concerns were raised about the need for long range planning, and whether one Council meeting per month would be enough to accomplish all the work that needs to be done. Support was expressed for the strengthening of Committees through the proposed structure, and the need for enhanced communication between committees and the Council members. Consensus was that the goal is to get the work done, and to adopt whatever structure will facilitate this. The Committee proposed additional language be added to the description of The Evaluation Committee, as follows: "..., and other evaluative tasks, as required by HRSA".

Next Meeting, Draft Agenda

The Evaluation Committee will meet on **Monday, December 7, from 5PM - 7PM** at 25 Van Ness. The proposed agenda will include a review of the '98 implementation, and a review of the AIDS Office draft of the proposed implementation plan for FY '99, to be distributed in advance. Any questions or requests concerning the agenda should be directed to Ali Riker, or Fernando Chavez, Co-chairs.

PROPOSAL

1998-1999 HIV Health Services Needs Assessment

Goals:

1. To determine the health and service needs of people living with HIV/AIDS in the San Francisco EMA, including those not in care.
2. To identify barriers to care for people with HIV/AIDS, especially barriers to medical care and treatment.
3. To quantify the unmet needs for services, especially medical treatment.
4. To determine the impact that HAART is having on the type, scope, and complexity of needs.
5. To evaluate the extent to which consumers experience a client-centered system of care, and receive high-quality CARE-funded services.
6. To quantify changes in needs and unmet needs over time (i.e. since the 1996 assessment)

Proposal:

1. A comprehensive survey of current clients at HIV programs. Questions based on prior needs assessments, with some modification. Use Reggie as mechanism as feasible, or self-administered surveys.
2. Assessment of PLWH not in care. Identify mechanisms to reach those out of care. Questions to focus on barriers to care, reasons not in care, unmet needs. Augment with information from ongoing research efforts in disenfranchised communities.
3. Focus groups on the impact of treatment on service needs. Qualitative information about treatments, access, effect on use of services, return to work issues. Questions about system of care. Include client satisfaction questions. Groups based on population/community/ neighborhood factors.
4. Community input forums, with similar questions, to elicit comparable information about barriers to care, service needs, access to treatment, impact of new drugs, and system of care.
5. Survey or focus groups of providers. Questions about needs, gaps in system.
6. Possible add-ons: return to work, African Americans, Latinos, prevention.

Preliminary process:

1. Convene a needs assessment work group, with Council members and AIDS Office staff. Meet regularly to set goals and objectives, review survey instruments and mechanisms, outreach to communities to encourage participation, coordinate sections of the assessment, and participate in presentation of results.
2. Determine mechanism of administration. Issue alternative solicitation, hire staff, or develop workplan with AO staff as needed.
3. Set timeline, budget, scope, responsibilities of all partners.

Resources:

1. AIDS Office staff time: Laura, Epi & Eval and Research staff.
2. Planning Council Support budget: FY 98-99 and 99-00
3. SFSU interns
4. Return to work contribution
5. Other funds: African-American initative, prevention?

HIV HEALTH SERVICES PLANNING COUNCIL

November 16, 1998

The Agenda of this meeting is missing.

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HIV Health Services Planning Council — Minutes of Meeting, November 16, 1998

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I. **Call to order:** 4:45 PM.

II. **Roll Call** [1]
TC holds proxy to vote on behalf of *MD.*

III. **Review and Approval of Agenda:** None

IV. **Review and Approval of Minutes:**
9/21/98 minutes approved, *DCB, EW, KW* abstained.
10/19/98 minutes approved, *DCB, BC* abstained.
10/26/98 minutes approved, *DCB, SO, BVB* abstained.

V. **General Announcements:**
A. *MJW* is the Council's representative to the State Title II workgroup. The State is reorganizing the Office of AIDS to combine the Title II working group and the Prevention Planning group. Preliminary recommendations for the new structure include: (1) two Title I representatives on the new working group out of the nine Title I areas in the State of California, with one representative each from northern and southern California. (2) Each Title I area will have a representative on a caucus. (3) There will be a two year rotation of representatives. She will advise the Council of the final recommendations in Dec. These changes could have a financial impact on the local Eligible Metropolitan Area (EMA). *JB* said the changes are intended to reduce costs and to combine education, prevention, and care. He said Title II is now called the HIV Comprehensive Care Working Group which includes more than Title II functions. There is a mandated seat, because of direct funding from the Center for Disease Control (CDC), for San Francisco on the education and prevention side.
B. *MS* distributed a flyer for *Hype in the Headlines: How to Interpret AIDS News in the Media,* a Provider Work Group meeting of the Treatment Education Certification Program, on Monday, November 23, 1998, 1:00 to 4:00 PM, at the Asian & Pacific Islander Wellness Center, 730 Polk St., 4th floor.
C. *DJ* circulated a revised Council membership list for corrections.
D. *Laura Thomas* distributed: (1) and article from AIDS CARE entitled "Reducing financial barriers to HIV-related medical care: does the Ryan White CARE Act make a difference?" based on CARE needs assessment. (2) The Health Resources and Services Administration (HRSA) September newsletter with an article entitled "Measuring success: Evaluation, Outcomes, and Quality of HIV Care." (3) A report from the General Accounting Office on HIV/AIDS drugs funding implications for federal and state programs. (4) An agenda for the HRSA conference call on underserved populations.
E. *KW* announced that Marin AIDS Project is looking for a Case Manager/Benefits advocate.
F. *WC* will speak about HIV and changes in revenue, at the Mayor's leadership forum, on November 30, 1998.

VI. **Public Comment:**
A. *Jim Illig*, from the HIV Contractor's Assn., announced they will be evaluating last year's allocations process of the Council. A report on the results of the survey will be made to the Council's Evaluation Committee in Dec.
B. *Mary Jane O'Connor*, Clinical Director of the Women's HIV program at Iris Center, introduced herself.
C. *Steve del Valle,* a new resident in San Franciso, who worked in the HIV Peer Education Program at Vacaville, would like to do similar work in the S.F. Latino community.
D. *TC* welcomed Mike Shriver, former Co-Chair of the Council, to the meeting.
E. *TC* welcomed and introduced *Darrell Joe (DCJ)* to the Council.

VII. **Committee Reports:**
A. Membership Committee - Co-Chair Election Process. **(VOTE)**
BVB distributed a letter from the Mayor in which he appointed Darrell Joe to the Council. The letter stated the Mayor was unable to appoint the other candidates because, "First, just four names were submitted for three available seats, and it has been my understanding that the Council will refer at least two names for each available seat. . . . Second, per your direction, a majority of my appointments are HIV positive, to maintain the required ratio of HIV positive council members. If I were to appoint one HIV negative person at this time, it would not be in keeping with the Council's written request." The Membership Committee will discuss these issues and bring a recommendation to the full Council.

BVB reviewed the Committee's recommendations on a voting mechanism for the Co-Chair elections.
Discussion: *SJ* withdrew his name from nomination. *TL* said no person can be elected without a majority of those voting. *TC* said language needs to be included stating who has been elected and how.
- TL offered an amendment to the recommendations to read "*the top three votegetters are elected to Co-Chair by a plurality vote.*"

KW argued for more than one vote and thought it was reasonable for nominees to be required to get a majority vote.

The motion to amend the recommendation failed, the vote was 14 yes, 8 no, 6 abstain. [2]
TC said there needs to be language included to explain the outcome of the vote. *TL* said that, according to the bylaws, the Council can adopt a majority vote.

- DCB offered an amendment to the recommendation to read "*The top three votegetters will be considered elected if they meet the demographic requirements of the bylaws, and have each received a simple majority of the votes cast.*

The motion to amend the recommendation passed. The vote was 26 yes, 2 abstain. [3]
TL pointed out that the entire vote must be retaken if any one of the top three votegetters does not get a simple majority vote.
The amended motion passed. The vote was 26 yes, 2 abstain. [4]
The next Membership Committee meeting will be Wednesday, December 2, 1998, 11:00 AM to 1:00 PM, at 25 Van Ness.

B. PWA Caucus - Notice of Proposed Bylaws revision.
TL referred to the *Proposed Amendment to the Council Bylaws* sent to Council members in which Article IV of the Bylaws would be amended by the addition of Section 10 that would describe the duties of the Caucus. *DJ* noted that the proposed bylaw change needs 30 day notification before it can be voted on by the Council, so discussion of this topic will take place at the December 21 Council meeting. *TL* said the 1999 Workplan is in draft form and will be completed in December. He said there are now four Community forums scheduled for December and asked Council members to try to stick to the schedule for these events. *LO'C* said the Women's Forum will be held on Thursday, Dec. 3, 1998, 3:00 to 4:30 PM, at Lyon-Martin Clinic, 1748 Market St. The African-American Forum will be held on Dec. 10. 1998. The next PWA Caucus meeting is Wednesday, January 6, 1999, from 5:00 to 7:00 PM, 25 Van Ness, Room 330A.

C. Evaluation Committee.
AR referred members to the Committee report. She said the Needs Assessment Task Force had its first meeting last week and discussed a budget, timeline, and solicitation. The next Task Force meeting is scheduled for Thursday, Nov. 19, 1998, 4:00 PM, at 25 Van Ness, in Room 330B. *MJW* noted that she attended the 11/2 Evaluation Committee meeting. *AR* said that a solicitation letter would be faxed this week. The next Evaluation Committee meeting will be on Monday, Dec. 7, 1998, 5:00 to 7:00 PM, at 25 Van Ness.

D. Housing Committee - Approval of Housing Opportunities for People With AIDS (HOPWA) Loan Committee representative. **(VOTE)**
TC spoke about the housing resource distribution problems, the under-utilization of Emergency Housing Vouchers and Shallow rent subsidies. *AR* and *TC* will attend the next Integrated Service Agencies meeting on Monday, Nov. 23, 1998, from 3:30 to 5:00 PM, at 25 Van Ness, Room 330B, to review the changes made in the Housing category during last year's prioritization. The Housing Committee supported the proposed Committee structure to become a Workgroup that will meet April to August. The Committee agreed that it would hold ad hoc meetings, as needed, when the Housing Prioritization Workgroup is not meeting, to address housing concerns relevant to the Council. He suggested identifying Council members willing to serve on other existing housing policy bodies such as the Supportive Housing Subcommittee of the Comprehensive Housing Affordability Strategy (CHAS), Housing Wait List/HOPWA Subsidy Advisory Committee, and the Local Board on Homelessness. The Committee recommended the Council approve *AR* as its second representative on the HOPWA Loan Committee. *DCB* asked if there had been discussion of having a Council member who lives in HOPWA funded housing fill that post. *TC* said that there had been discussion of adding consumers to the HOPWA Loan Committee, and asked if any Council members who currently were, or had in the past been, HOPWA fund recipients would like to fill the vacant seat. *DB* said she had been a HOPWA client and offered to be an alternate.

- *TC* presented a motion "*to have AR serve on the HOPWA Loan Committee as the Council's second representative with DB named as an alternate.*"

The motion passed without objection.

VIII. **Steering Committee - Proposed Organizational Structure: (VOTE)**
TC reviewed the Proposed Committee Structure document changes that were noted in italics: (1) The Implementation & Evaluation Committee added the wording "and other evaluative tasks, as required by HRSA." to their description. (2) The PWA Caucus added the sentence "The Caucus is also responsible for ensuring that input from PLWH/AIDS is included in the Council's prioritization and allocation plan." (3) The Housing Committee added a note that, "The Housing Committee will no longer be a standing Committee, but will meet as an AD Hoc Committee, as needed, from September through April when the Housing Workgroup will reconvene." He pointed out that the proposed Committee structure reflects how the Committees currently work. *DJ* restated concerns that arose during discussion: (1) Clarifying the voting process in Committees. (2) The standard for attendance (which the Membership Committee will review). (3) Committee meetings all being held the first week of the month. (4) The issues of planning functions.
MJW called the question on the proposed Committee structure.
The proposal as stated passed unanimously. [5]

IX. **Prioritization Evaluation - facilitated discussion:**
DJ referred to the worksheet for the *Evaluation of FY 1999-2000 Prioritization Process* consisting of Discussion Points, and Topics. She pointed out that some of the topics are HRSA mandated.

- Positive aspects of the content: (1) continued emphasis on integration; (2) increasing emphasis on outreach; (3) introduction of harm reduction definition; (4) changes made in the Home Health category.
- Negative aspects of the content: (1) no evaluation of what was done last year; (2) no changes were made to the Substance Abuse category toward harm reduction or integration; (3) the Case Management category should have been held harmless; (4) unmet need in underserved populations; (5) using only contracts and Requests For Proposals (RFP) to motivate integration.
- Positive aspects of the process: (1) more community input; (2) more systematic involvement for contractors through the Service Category Task Force; (3) in-depth understanding due to discussions by service category.
- Negative aspects of the process: (1) being too compressed; (2) weak input from community forums and PWA Caucus; (3) lack of independent Council analysis and concensus on recommendations.

DJ thought the new structure would alleviate the lack of time the Council had to arrive at its own conclusions. *KB* suggested there needs to be a clear voice from the AIDS Office about what they'd like to see happen. *JAC* thought there was not sufficient data on children. She also suggested a mobile team to go to clinics to assist in gathering community input before the task force groups meet. *DCB* asked why the Mental Health category should not be held harmless. *DJ* responded that General Funds are committed to cover Mental Health. *KW* said that Epidemiology and Utilization data is needed sooner in the process. *JB* asked the Council for a list of information that would be useful earlier in the prioritization process. *Laura Thomas* said she can start scheduling presentations now if she has direction from the Council. *LO'C* thought some of the community forums were very good but the information from those meetings did not get passed on to the Council. She was frustrated by the lack of implementation of harm reduction. *AM* thought that implementation needs to begin as soon as prioritization is complete. *TC* said that implementation is crucial and needs a plan that includes timelines. On content, he said there is not enough housing, and the Council is not being realistic about the CARE funds and how they are spent. He does not think it's appropriate to have a category called Substance Abuse that does not address the needs of all the people who use drugs. *KW* thought the Transgender presentation was a great example of providing concise information that was not available elsewhere, while some Substance Abuse presentations did not provide sufficient or useful information. He said the Council needs to respect difference of opinion within the Council and not create right and wrong answers to topics. *CB* did not see an emphasis put of the youth aspect of HIV. *DB* said the rental housing cap for the local EMA was not addressed during prioritization. *TL* said community forums are scheduled throughout the prioritization process this year so some data will be available before the process begins and additional information can be gathered during the process. *DJ* said there needs to be more structure to the community forums and task force meetings so that the Council gets more useful information and the discussions are more focused. There is also a conflict of interest question that arises in many discussions. *TC* suggested requiring participants in workgroups to disclose their affiliation. *JC* said there was a problem this year with the Council having to listen to presentations during Public Comment that had already been given to a focus workgroup. *DCB* thought the Council needs to keep an open mind about hearing public comment. He thought the last Latino forum brought a variety of issues about how service providers work in the community, how they might be more effective, and how the Council might support that. *FC* suggested one Council meeting during the prioritization process devoted to public comment. *CB* said the Council can't take direct action for community problems and wondered how relevant public comment was under those circumstances. *KW* suggested focusing on category discussion and not engage in contract discussion. *LO'C* said many items stayed the same this year because of the changes made the year before.

X. **New Business:** None.

XI. **Adjournment:** 7:35 PM

The Council meets on the third and fourth Mondays of each month, at the time and place noted above. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For HIV-Positive members requesting excused absences due to illness, contact Tom Calvanese at 621-7712. *Minutes of meetings are tentative until formally approved by the Council.*

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-]: **Y**=Yes; **N**=No; **B**=Abstain

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	P	Y	Y	Y	Y							
Marianna Balquiedra	P	Y	Y	Y	Y							
Dorothy Bartolomucci	P	Y	Y	Y	Y							
Donald C. Bliss	P	N	Y	Y	Y							
Chris Boehm	P	B	Y	Y	Y							
Jeff Byers	P	Y			Y							
Virginia Cafaro	P	Y	Y	Y	Y							
Tom Calvanese	P	Y	Y	Y	Y							
William Carter	P	B	B	B								
Bart Casimir	P	Y	Y	Y								
Veronika Cauley	A											
Julie A. Charubusapayon	P	Y	Y	Y	Y							
Fernando Chavez	P	Y	Y	Y	Y							
John Conley	P	N	Y	Y	Y							
Mark Dunlop	E	N	Y	Y	Y							
Mariam Farooq	A											
Gene Gowdey	P	Y	Y	Y	Y							
Siddiq Jihad	P	B	Y	Y	Y							
Darrell C. Joe	P	B	B	B	B							
Diane Jones	P	N	Y	Y	Y							
Tony Leone	P	N	Y	Y	Y							
Allen Meyer	P		Y	Y	Y							
Leann Monfredini	A											
Norm Nickens	P	B	B	B	B							
Lisa O'Connor	P	B	Y	Y	Y							
Loras Ojeda	A											
Jorge Ortiz	P	Y	Y	Y	Y							
Stephan Oxendine	P	B	Y	Y	Y							
Alissa Riker	P	Y	Y	Y	Y							
Nilda Rodriguez	P				Y							
Matthew Sharp	P	Y	Y	Y	Y							
Susan Shea	A											
Thomas Sinclair	A											
Brett VanBenschoten	P	Y	Y	Y	Y							
Kelly Wallace	P	Y	Y	Y	Y							
Eric Whitney	P	N	Y	Y	Y							
Mary Jane Wood	P	N	Y	Y	Y							

DRAFT

HIV HEALTH SERVICES PLANNING COUNCIL

November 23, 1998 4:30 - 7:30 PM

25 Van Ness, 3rd Floor Conference Room

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Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	4:35 PM
III.	Review and Approval of Agenda	4:40 PM
IV.	Review and Approval of Minutes from 7/20, 7/27 and 8/17	4:45 PM
V.	General Announcements	4:50 PM
VI.	Public Comment	4:55 PM
VII.	Co-chair nominations - VOTE to close nominations	5:00 PM
VIII.	Proposed Bylaws revisions - VOTE	5:05 PM
	BREAK	6:15 PM
IX.	Co-chair election - VOTE	6:30 PM
X.	New Business	7:25 PM
XI.	Adjourn	7:30 PM

Future Meetings:

Wednesday, December 2, 1998 - **Membership Committee**, 25 Van Ness Ave., 11:00 AM - 1:00 PM
Wednesday, December 2, 1998 - **PWA Caucus**, 25 Van Ness Ave., 5:00 PM - 7:00 PM
Thursday, December 3, 1998 - **Women's Community Meeting**, Lyon Martin, 1748 Market St. (time TBA)
Monday, December 7, 1998 - **Evaluation Committee**, 25 Van Ness Ave., 5:00 PM - 7:00 PM

San Francisco Department of Public Health – AIDS Office, 25 Van Ness:

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AIDS Office
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SF H22 #2
11/23/98 draft

HIV Health Services Planning Council — Minutes of Meeting, November 23, 1998

DRAFT

I. **Call to order:** 4:40 PM.

II. **Roll Call:** [1]
TC held proxy to vote on behalf of *NR*.
DJ held proxy to vote on behalf of *LO'C*.

III. **Review and Approval of Agenda:** *TL* suggested there needs to be a statement on the agenda that times are approximate and are for guidanee only.

IV. **Review and Approval of Minutes:**
7/20/98 minutes were approved, *VC, SJ, SO, EW* abstained.
7/27/98 minutes were approved, *MB, BC, VC, SJ, AR, EW* abstained.
8/17/98 minutes were approved, *SJ, EW* abstained.

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V. **General Announcements:** None.

VI. **Public Comment:**

A. *Michael Petrelis* asked to have minutes from this meeting mailed to him. He said he had a eonversation with *LM* regarding Dana Van Gorder who has been the gay liaison with the Department of Publie Health (DPH) for four years and who is having his first public meeting tonight at 6:00 PM at 101 Grove St. Mr. Petrelis thinks Mr. Van Gorder should be removed from his position and his replaeement should meet regularly with the gay eommunity. He asked the Couneil to eontaet him with any follow-up on this issue. WC asked if the Council should respond to this issue. *NN* said this was not a Couneil matter.

B. *Ruthy Talansky*, Projeet Manager, Bridge Housing Corp., asked the Couneil for a letter to support a housing project at 1 Chureh St. This would be a 93 unit complex, with 12 units designated for people living with AIDS, funded through Housing Opportunities for People With AIDS (HOPWA). There has been opposition from the neighborhood whieh wants one third of the units owner oeeupied and fewer total units. There will be a meeting with the Mayor, Wednesday, Nov. 25, at 10:00 AM to diseuss this projeet. Bridge Housing Corp. would like the Council's support letter before that meeting. *NN* said there would need to be two motions voted on, one to deelare this a matter of emergeney that eame to the Couneil's attention after the agenda was announeed, whieh would need a two-thirds majority, and a seeond motion to approve sending a letter.
   - *VC* proposed a motion "*To declare the 1 Church St. housing project request for a letter of support an urgent matter for the Council's consideration at this meeting.*"

   WC objeeted to the motion beeause this is a eomplex situation and the Couneil needs time to researeh the issues. *JC* agreed that this process was being rushed. *SO* asked why the neighborhood wanted more owner oeeupied housing. *Ruthy* said that in the eommunity meeting people said owners make better neighbors. *FC* thought one parking space per unit would not be enough in that neighborhood. *Ruthy* said at Bridge's other inner city developments where there is a 1:1 ratio of parking to units, 15% of the parking is unused or rented.
   The motion passed. The vote was 15 yes, 6 no, 5 abstained. [2]
   DJ read the draft proposal letter submitted by Bridge Housing Corp. *JB* asked if the number of HOPWA supported units would remain the same if the total number of units were redueed. *Ruthy* said there might be a proportional reduetion of those units.
   - *TC* motioned that "*The Council sign the proposed letter of support for the 1 Church St. Housing Project.*"

   DCB was eoneerned about a blanket approval of the projeet. *TC* said that the HOPWA Loan Committee, as well as the Mayor's Offiee of Housing, approved this projeet, and he believes it warrants the Couneil's support. *JB* was eoneerned about approving this speeifie projeet without hearing from the eommunity that is opposed to it. *Bill Barnes* said there is widespread support for this projeet in the Mayor's administration. He suggested that individual letters from Couneil members might be more appropriate. *TL* suggested moving this issue to the Steering Committee. *DJ* recommended supporting the projeet since it has been through the meehanisms set up by HOPWA and the Mayor's Offiee. *NN* ealled the question.
   The motion passed. The vote was 18 yes, 4 no, 6 abstained. [3]

C. *Bill Barnes*, AIDS Poliey Advisor, Mayor's Offiee, distributed a memo stating the Mayor's position that at least two names be submitted for eaeh available Couneil seat, and his opposition to the bylaw's amendment regarding length of terms. *SJ* asked for a larger spaee for the Couneil to meet in. *Bill Barnes* said that most eity government spaees would not aeeommodate a group of this size.

D. *Laura Thomas*, Planner, HIV Health Serviees, passed around a sign-up sheet for the Needs Assessment Workgroup. *SJ* was eoneerned that Needs Assessment data is an aeeurate refleetion of population need. Who is eolleeting the data is important. *Laura* said language refleeting that eoneern has been ineluded in the Needs Assessment draft proposal.

VII. **Co-chair nominations - VOTE to close nominations:**
The nominees were: Tom Calvanese, Veronika Cauley, Diane Jones, Tony Leone, Nilda Rodriguez. The Couneil voted to elose the nominations.

VIII. **Proposed Bylaws revisions: VOTE**

A. ARTICLE III. Sec. 3. The term of office on the Planning Council shall be two years. ~~a minimum of one year, with the option of reappointment by the Mayor.~~

BVB said the intent of this amendment is to foster stability within the Council while allowing for changes in shifting demographics. This language clarifies what a term of office on the Council means. This change means that members must reapply for appointment just as a new applicant would, and the Mayor retains full power of appointment of all recommendations brought to him by the Council. *DJ* said the Council will not be voting on whether this amendment is retroactive, it applies to all future appointments. *TL* said there needs to be a transition plan in all bylaw changes. Without that there needs to be a commitment about how long the change will take. *LO* suggested establishing a Task Force to create a transition plan. *NN* asked if the Council was being asked to approve a bylaws change whose intent would be determined later. *DJ* said the intent is clear, this is a simple proposal for a change that is in the best interest of the Council. It will be the responsibility of the Steering Committee to figure out how to implement the change. *FC* supported the change, he felt it takes time to understand how the Council works and to get involved in a significant way. *BVB* would like to work on the transition team. *JB* spoke in favor of the motion and said it was not unusual for a Council to have terms of two years. He suggested including appointment and end dates to a roster of Council members. *TL* would like a motion for the Membership Committee to come back with a transition plan in the form of a bylaws amendment. He had mixed feelings about two year terms, which can be a long time to someone whose health is fluctuating. He pointed out that the bylaw needs an explanation written in about the process that is used to govern the body. *SJ* asked if the Chief Executive Officer (CEO) of the Eligible Metropolitan Area (EMA) has the authority to veto bylaw changes. *DJ* said the Health Resources and Services Administration (HRSA) gives the Council the purview to establish bylaws and gives guidance about the types of issues to address. *Jean Fraser*, Deputy City Attorney, City Attorney's Office, said they were requested to review the matter of bylaws for the Council and that it is the opinion of their office that the CARE Act does not give the Council power to create bylaws. *WC* asked her who requested their office to research this matter. She said *NN* had made the request. *KW* supported the change because a two year term is more effective but was concerned about asking people to serve that long. *NN* said he asked both the City Attorney's Office and HRSA to weight in on the language of the bylaws because of discussion in the last Steering Committee meeting. The question of whether the language could be retroactive was also brought up in the Membership Committee. It is his opinion that the language cannot be made retroactive. *TC* spoke in favor of the change because the current language is unclear. He said the Council has always made accommodations for people who could not fulfill their terms. He noted that the current language of the bylaws has a destabilizing effect on the Council due to the Mayor's ability to withhold reappointment. *WC* supports the two year term. He thought the lack of reappointment of Barry Savage was never adequately explained by the Mayor's Office. The intent of the language change is saying the Council has the right to govern themselves as they see fit. *BVB* said there had been discussion in the Membership Committee of length of term and they concluded that two years was the best choice. He said it is clearly stated by the HRSA guidelines, on the roles and responsibilities of the CEO, that the membership of the Council not be politicized. *DJ* said it's not in the interest of the Council or the community it serves to continue debating this issue with the Mayor's Office. Voting to support this change lets the Mayor know that the Council believes this is in their best interest. If the vote passes there can then be a discussion with the Mayor.

- *KW* proposed an amendment to the amendment that "*The term of office on the Planning Council shall be two years for all members appointed after 11/23/98. Individuals may apply for subsequent terms.*"

TL argued against the process of reapplying for office. He thought the amendment should be divided into two issues. He's afraid the approval of this amendment may prevent the Council from being able to appoint people. *KW* thinks it's important for Council members to take a step back every two years and reevaluate their commitment to being on the Council. *LO* thought the amendment crossed the line into implementation and argued for the originally proposed change. *TC* agreed that there were two questions within this amendment. He thinks it's a mistake to include a specific date at this time because that precludes coming up with any other solution. *SO* disagreed with the City Attorney's Office assessment of the bylaws. He thought the language needed to be cleaned up. *FC* called the question.

The motion to amend the amendment failed. [4]

DCB called the question on the bylaw revision to ARTICLE III. Sec. 3.

The amendment passed. The vote was 19 yes, 7 no, 1 abstained. [5]

B. ARTICLE III. Sec. 4. The Council shall elect, using a voting mechanism determined by the Council, ~~at the first meeting in January,~~ three Co-Chairpersons who shall preside at all meetings of the Council.

LO said this amendment would make the bylaw language agree with the existing practice of the Council. *MS* called the question.

The amendment passed unanimously. [6]

C. ARTICLE III. Sec. 5. Members are required to serve well and to faithfully discharge their duties and responsibilities diligently and consistent with the laws of the City and County of San Francisco, and all pertinent state and federal laws.

LO said the addition of this Section to the bylaws is intended to establish a code of conduct for Council members in public settings. The language is taken from the SF Ethics Commission. *JB* asked what happens if

someone does not serve well. He said this sounds like language that should be inserted under regulations for termination of membership. *TL* call the question.
The amendment failed. [7]

D. ARTICLE VI. - MEETING ATTENDANCE/TERMINATION.
This heading addition is intended to clarify the subjects covered within its sections.
The amendment passed unanimously. [8]

E. ARTICLE X. - REPRESENTATION OF THE COUNCIL
Whenever a Council member communicates with the news media, or appears at a public meeting or before another City Department to discuss existing or proposed Council policy, the Council member will make every reasonable effort to explain to the Council's audience whether the Council member is expressing an opinion, view or position that is the individual Council member's or a view, position or opinion of the Council as a whole.
Whenever the Council learns that a view, position or opinion of the Council as a whole has been misinterpreted or misrepresented in the media, or at a public meeting, the Council, through the Co-chairs or the Co-chairs' appointed representative, shall make every reasonable effort to promptly clarify the Council's true position as soon as practicable, and within a period not to exceed 45 days.
BVB said the addition of this article was in response to community concerns that issues of importance were not being addressed promptly.
The amendment passed unanimously. [9]
MS asked what the disciplinary process would be. *TL* said Robert's Rules of Order describes a number of levels of disciplinary action up to expulsion from the Council.

F. ARTICLE XI.
This amendment is a numerical change due to the addition of the new ARTICLE X.
The amendment passed by voice vote.

- *DCB* proposed a motion "*To instruct the Steering Committee to address questions of implementation of terms and submit a report of their findings to the Council by the January 1999 Council meeting.*"

The motion was not seconded.

IX. **Co-Chair Election: VOTE**
The newly elected Planning Council Co-Chairs were Tom Calvanese (21 votes), Diane Jones (21 votes), and Nilda Rodriguez (20 votes). [See attachment for final tally]

X. **New Business:**

A. *LO* said a response to the Mayor's letter of November 6, 1998, regarding the number of submissions for Council seats was discussed at the Membership Committee meeting on December 2, 1998.
B. *JB* requested that the roll call be read in alternate alphabetical order. The Council agreed.
C. The Women's Community Meeting will be held Thursday, December 3, 1998, 3:30 to 5:00 PM, at Lyon-Martin, 1748 Market St. The African American Forum will be held on Thursday, December 10, 1998, from 4:00 to 6:00 PM, (location to be announced). Child care is available for both meetings with 48 hour notice.
D. *Laura Thomas* announced a public meeting with Nancy Pelosi, Congressional Representative, on December 2, 1998, 2:00 PM, at 450 Golden Gate Ave. San Francisco.

XI. **Adjournment:** 7:35 PM

The Council meets on the third and fourth Mondays of each month, at the time and place noted above. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For HIV-Positive members requesting excused absences due to illness, contact Tom Calvanese at 621-7712. *Minutes of meetings are tentative until formally approved by the Council.*

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-]: **Y**=Yes; **N**=No; **B**=Abstain

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	P	B	Y	N	Y	Y	Y	Y	Y			
Marianna Balquiedra	P	N	N									
Dorothy Bartolomucci	P	Y	Y	N	Y	Y	Y	Y	Y			
Donald C. Bliss	P	Y	B	N	Y	Y	Y	Y	Y			
Chris Boehm	P	B	Y	B	Y	Y						
Jeff Byers	P	N	B	Y	N	Y	N	Y	Y			
Virginia Cafaro	A											
Tom Calvanese	P	Y	Y	N	Y	Y	N	Y	Y			
William Carter	P	B	B	B	B							
Bart Casimir	P	N	N	Y	Y	Y	Y	Y	Y			
Veronika Cauley	P	Y	Y	B	Y	Y	N	Y				
Julie A. Charubusapayon	A											
Fernando Chavez	P	Y	Y	Y	Y	Y	Y	Y	Y			
John Conley	P	N	N	N	N	Y	Y	Y	Y			
Mark Dunlop	A											
Mariam Farooq	A											
Gene Gowdey	A											
Siddiq Jihad	P	B	B	N	Y							
Darrell C. Joe	P		Y	B	Y	Y						
Diane Jones	P	Y	Y	N	Y	Y	N	Y	Y			
Tony Leone	P	Y	Y	N	N	Y	N	Y	Y			
Allen Meyer	P	Y	Y	Y	N	Y	Y	Y	Y			
Leann Monfredini	A											
Norm Nickens	P	N	N	Y	N	Y	Y	Y	Y			
Lisa O'Connor	E		Y	N	Y	Y	N	Y	Y			
Loras Ojeda	P	Y	Y	N	Y	Y	N	Y	Y			
Jorge Ortiz	P					Y	N	Y	Y			
Stephan Oxendine	P	N	B	N	N	Y	N	Y	Y			
Alissa Riker	P	Y	Y	N	Y	Y	N	Y	Y			
Nilda Rodriguez	P	Y	Y	N	Y	Y	N	Y	Y			
Matthew Sharp	P	Y	Y	N	Y	Y	N	Y	Y			
Susan Shea	P	Y	Y	Y	Y	Y	N	Y	Y			
Thomas Sinclair	A											
Brett VanBenschoten	P	Y	Y	N	Y		N	Y	Y			
Kelly Wallace	P	B	B	Y	N		N	Y	Y			
Eric Whitney	P	Y	Y	N	Y	Y	N	Y	Y			
Mary Jane Wood	A											

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11/23/98

'98 Co-Chair Election Candidates

	Tom Calvanese	Veronika Cauley	Diane Jones	Tony Leone	Nilda Rodriguez
Kirsten Balano	X	X	X		
Marianna Balquiedra					
Dorothy Bartolomucci	X		X		X
Donald C. Bliss					
Chris Boehm	X		X		X
Jeff Byers	X		X		X
Virginia Cafaro					
Tom Calvanese	X		X		X
William Carter					
Bart Casimir	X		X		X
Veronika Cauley		X		X	X
Julie A. Charubusapayon					
Fernando Chavez	X		X		X
John Conley		X		X	X
Mark Dunlop					
Mariam Farooq					
Gene Gowdey					
Siddiq Jihad	X		X		X
Darrell C. Joe	X	X			
Diane Jones	X		X		X
Tony Leone		X	X	X	
Allen Meyer	X		X		X
Leann Monfredini					
Norm Nickens					
Lisa O'Connor	X		X		X
Loras Ojeda	X		X		X
Jorge Ortiz					X
Stephan Oxendine	X		X	X	
Alissa Riker	X		X		X
Nilda Rodriguez	X		X		X
Matthew Sharp	X		X		X
Susan Shea	X		X		X
Thomas Sinclair					
Brett VanBenschoten	X		X		X
Kelly Wallace	X	X	X		
Eric Whitney	X		X		X
Mary Jane Wood					

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12/21/98

HIV HEALTH SERVICES PLANNING COUNCIL

December 21, 1998 4:30 - 7:30 PM

25 Van Ness, 3rd Floor Conference Room

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Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	4:35 PM
III.	Review and Approval of Agenda	4:40 PM
IV.	Review and Approval of Minutes from 11/16 and 11/23 (VOTE)	4:45 PM
V.	General Announcements	4:50 PM
VI.	Public Comment	4:55 PM
VII.	Report from Title II Consortium - Mary Jane Wood	5:00 PM
VIII.	Mayor's Liaison Report - Bill Barnes	5:10 PM
IX.	Committee Reports	5:20 PM

A. Evaluation and Implementation Committee
   1. AIDS Office Draft of 99-00 Implementation Plan
   2. Needs Assessment - update
   3. Evaluation of 98-99 Implementation

B. Membership Committee - Report

C. PWA Caucus - Bylaws Revision - VOTE

X.	Steering Committee - Report	6:15 PM
XI.	New Business	6:25 PM
XII.	Adjourn - Celebration of 1998!	6:30 PM

Future Meetings:

Monday, 1/04/99 - **Needs Assessment Task Force**, 25 Van Ness, Training Room-A, 4:00 - 5:00 PM
Monday, 1/04/99 - **Evaluation & Implementation Committee**, 25 Van Ness, Training Room-A, 5:00 - 7:00 PM
Wednesday, 1/06/99 - **PWA Caucus**, 25 Van Ness, Suite 330-B, 5:00 PM - 7:00 PM
Thursday, 1/07/99 - **Membership Committee**, 25 Van Ness, Training Room-A, 11:00 AM - 1:00 PM
Monday, 1/11/99 - **Grantee Assessment Task Force,** 25 Van Ness, 5th Floor Conference Room, 4:00 - 5:00 PM
Monday, 1/11/99 - **Steering Committee**, 25 Van Ness, 5th Floor Conference Room, 5:00 - 7:00 PM
Monday, 1/25/99 - **Planning Council,** 25 Van Ness Ave., Suite 330-A, 4:30 PM - 7:30 PM

San Francisco Department of Public Health – AIDS Office, 25 Van Ness:

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Minutes of Meetings are tentative until formally approved by the Council.

HIV Health Services Planning Council

PWA Caucus

25 Van Ness Ave, 5th Floor
San Francisco, CA 94102

November 4, 1998

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TO: HIV Health Services Planning Council

FROM: Tony Leone, Co-Chair PWA Caucus

RE: Proposed Amendment to the Council Bylaws

The PWA Caucus has voted to present the following motion to amend the Bylaws to the full Council for action.

MOTION:

To amend Article IV of the Bylaws by adding a new section as follows:

Section 10. The PWA Caucus is a standing committee of the Council which meets regularly and reports regularly to the HIV Health Services Planning Council providing input and advice on all matters pertaining to PLWH/AIDS through the planning, prioritizing, implementing, and evaluating processes of the Council. The duties of the PWA Caucus include:

A) Oversee progress toward goal of "fully involving People Living with HIV/AIDS, PWAs in the design, implementation and governance of the system.
B) Participate in new Council member orientation.
C) Coordinate the efforts of the Council in conducting community meetings, forums, focus groups, panels and other methods for Council input from consumers of CARE-funded services as well as potential consumers.
D) Participate in the development and implementation of Community assessment techniques including consumer satisfaction measurements, focus groups, needs assessment, input from other Community groups, including Service Providers.
E) Provide education about the Council and the PWA Caucus activities to the Community and to specific consumers.
F) Ensure that input is brought into the Prioritization Process in a meaningful way.

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HIV Health Services Implementation Plan
(Beginning 1999-2000: Multi-Year)

Draft
11/19/98
Revised 12/7/98

This implementation plan incorporates the program changes proposed by the HIV Health Services Planning Council during its prioritization process for 1999-2000 funding as well as projects proposed by the grantee for the same period. Program changes that are predicated on the funding level of the 1999-2000 CARE grant award will be re-evaluated at the time that the funding amount is known.

The Project Team ("Staffing" category) includes members of the HIV Health Services Planning Council, either as individuals or committees, HIV Health Services staff, other DPH staff, and other appropriate community resources.

Key to Symbols:

(-) To be achieved if funding is decreased
(=) To be achieved if funding is level
(+) To be achieved if funding is increased
(UX) To be achieved if unexpended funds are available

DRAFT - FOR DISCUSSION ONLY

Sub-category: **Primary Care**

Standards of Care

1. Develop standards of care for provision of Primary Care services to persons with HIV/AIDS (=)

Standards of Care

2. Implement the standards of care in all funded services (=)

Evaluation

3. To evaluate changes in the provision of primary care and include an impact/outcome analysis component in the contractual scope of work (=,+)

Evaluation

4. To include adherence to treatment as an impact/outcome objective in CARE funded services contracts (=,+)

Activity	When	Staffing	Resources
Gather standards already developed	Prior to 3/99	Program manager Clerical staff Community participation	$ for internet access
Convene group of primary care providers to discuss implementation	Prior to 3/1/99	Program Staff	
Implement through contracts; Compare existing contract language for consistency; include adherence to treatment as an objective	3/1/99	Program Staff	
Monitor through contracts - use objectives in standards of care	End of year 1 and year 2	Program Staff	

Increase Service Capacity

5. To expand the integrated service model of care to include more services for African Americans, Latinos, and the incarcerated/newly released population. Services should be expanded by scope and sites of access (=,+)

Activity	When	Staffing	Resources
Analyze demographic information from existing integrated models to determine existing client mix;	2nd qtr, Year 1	Program Staff Clerical staff Contract staff	
Evaluate "success" of integrated models		Consultant	$ Planning Council Suppt, Evaluation
Look at surveillance data vs. data about # of/who is served; Break it down to determine who is eligible for services		Consultant	

DRAFT FOR DISCUSSION ONLY

Sub-category: **Primary Care Cont'd**

Activity	When	Staffing	Resources
Adjust the model to incorporate necessary services and appropriate sites of access		Program Staff	
If necessary develop an RFP, etc....	2nd qtr, Year 1	Program Staff Contract staff	$ for RFP

Increase Access

6. Develop drop-in centers for primary care services (+)

Activity	When	Staffing	Resources
Define "drop-in" services	Year 2 project	Council members Providers Other staff TBD	
Determine the need for drop-in and the scope of services to be provided ▪ Existing primary care sites; off hour calls ▪ Urgent care need during open hours			
Determine potential sites for expansion			
Establish mechanisms for continuity of care			
Develop alternate solicitation		Program Staff Contract staff	$ to hire more staff for existing centers to expand drop-in hours

Increase Service Capacity

7. Integrate the availability of Action Point Adherence Centers (APAC) into the models of integrated service provision (=,-)

Activity	When	Staffing	Resources
Need to evaluate existing integrated service models for adherence effectiveness to determine how the APAC can enhance the models' effectiveness	4th qtr, Year 1	Consultant Coordinator of APAC Providers	$ Planning Council Support
Get further definition of Action Point Centers		Coordinator of APAC	

DRAFT - FOR DISCUSSION ONLY

All of the following relate to an overall objective to evaluate the need for and capacity to include ancillary services in integrated models of care.

Sub-category: Dental

Evaluation

1. Evaluate the need for and potential capacity to include dental services within the integrated model of care (=,+)

Sub-category: Pharmaceuticals

Evaluation

1. Evaluate the need for and potential capacity to include pharmaceutical services within the integrated model of care (=,+)

Sub-category: Complementary Therapy

Evaluation

1. Evaluate the need for and potential capacity to include complementary treatment services within the integrated model of care (=,+)

Increase Service Capacity

2. To expand the integrated services model of care to include the provision of complementary treatment to the homebound (+)

Activity	When	Staffing	Resources
Conduct needs assessment ▪ Providers view ▪ Consumers needs	Year 1	Program staff ADAP coordinator Clerical staff	
Determine capacity of current providers to expand ancillary services	Year 1	Program Staff	
Determine what the CHN is already doing	Year 1	Program Staff	
Define services to be provided ▪ In case of pharmacy look at ability of ADAP pharmacies to expand services			

Implementation activities	Year 2 implement changes	Program Staff	$ for staff to provide additional services
			
			$ for pharmaceuticals

DRAFT FOR DISCUSSION ONLY

Sub-category: **Pharmaceuticals**

Evaluation

2. Evaluate the need for and potential capacity to contract out a portion of non-ADAP funding to the Mental Health Section for services to persons with HIV/AIDS within the Mental Health System of Care (-,UX)

Activity	When	Staffing	Resources
Determine how many patients are in current Mental Health system that are also in the CARE system	Year 1	Information systems staff	
Define the cost per scrip alternatives			

Sub-category: **Home Health: Home-based**

Enhance Quality Assurance

1. To provide in-home outreach and education to support adherence to multi-drug antiretroviral combination therapies (+)

Activity	When	Staffing	Resources
Include as an objective in 1999-2000 contracts with home health providers	To be included in 3/99 contracts	Program Managers	$ for staff and training expenses
Evaluate success of this modality	3rd qtr, Year 1	Consultant	$ Planning Council Support

Increase Access

2. Provide primary care to homebound PWA through a mobile health team (+)

Activity	When	Staffing	Resources
Determine # of PWA who do not have access to mobile health team ▪ Look at existing waiting lists, Ward 86, Tom Waddell, other primary care providers	Prior to 3/99	Program staff Contracts staff	
Define "home-bound"			
Determine which programs have the capacity to expand		Program staff	
Include program expansion in contracts	Implement in 3/99 contracts	Program staff	$ for program expansion

FOR DISCUSSION ONLY

Sub-category: **Home Health: Home-based Cont'd**

Evaluation

3. To conduct an evaluation of the utilization of services in this subcategory and redirect funds if the services are not being utilized at an appropriate level. (=,+)

Activity	When	Staffing	Resources
Review utilization data	2nd quarter, Year 1	Program Staff	
Review materials produced through activities associated with objective #2	2nd quarter, Year 1	Program Staff	

Sub-category: **Home Health: Residential Facility-Based**

Evaluation

1. Conduct an evaluation of the utilization of services within this subcategory, especially infusion and home hospice care, and redirect funds if the services are not being utilized at an appropriate level (=,+)

Activity	When	Staffing	Resources
Explore with B. Haskell and Long-Term Care Task Force the cost effectiveness of our models and possibilities for collaboration	Year 1	Program manager	
Examine utilization data			
Examine ICD9 data			
Examine ADAP and Medi-Cal billing data			
Talk to staff at facilities re: utilization of bed capacity vs. mixed use			

Enhance Quality Assurance

2. To reorganize services/contracts so that residential facilities have direct control over home health care provided at their facilities. (=,+)

Activity	When	Staffing	Resources
Make policy decision	Prior to 3/99	DPH staff	
Develop appropriate contract language	Prior to 3/99	DPH staff and providers	

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Sub-Category: Case Management

Evaluation

1. Evaluate changes in the provision of case management and include an impact/outcome analysis component (-)

Activity	When	Staffing	Resources
Convene meeting of CARE funded case managers to discuss changes implemented in 1998-99	End of 1st quarter (1/99)	Program managers/Consultant	$ for consultant
Examine contracts and case management monitoring reports and look at impact objectives – were they achievable?	End of 1st quarter	Consultant	$ for consultant
Analyze as a system			
Hold aside those programs that are part of integrated service models			
Determine award for category; establish cuts if necessary			

Increased Access

2. To achieve greater integration with client advocacy (=)

Activity	When	Staffing	Resources
Evaluate existing linkages	End of Year 1	Consultant/Prgm Managers	$ for consultant
Determine how legal services and benefits counseling fit into stand alone case management and integrated case management			

Increase Service Capacity

3. To increase services for any populations which are currently underserved (+)

Activity	When	Staffing	Resources
Define "underserved" ▪ Who is getting case management services? ▪ Waiting lists ▪ Demographics ▪ Utilization	Begin 5/99	Planning Council Program Staff	
Make appropriate recommendations			

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Sub-category: **Case Management Cont'd**

Increase Service Capacity/Access

4. Increase availability of case management services after hours and on the weekend (+)

Activity	When	Staffing	Resources
Determine need		Program manager	
Define what case management services might be needed after hours			
Expand contracts as necessary	Implement in 3/99 contracts		$ to fund after hour services

Increase Access

5. Make available more vouchers for transportation and household goods (UX)

Activity	When	Staffing	Resources
Build on existing voucher program	Begin after 3/99 ongoing	AO Staff	
Determine who has expended funds and allocate more vouchers		AO Staff	$ for more vouchers

Technical Assistance

6. Provide more training in case management standards (UX)

Technical Assistance

7. Provide training in harm reduction principles (UX)

Activity	When	Staffing	Resources
Establish bi-annual training for new-hires (either in-house or support center)	Year 1	Management Assistant	$ for trainer, location and materials
If in-house: develop/update curriculum		Consultant	$

8. Cut category proportionally (-)

9. Hold case management services harmless where they are components of integrated service models (-)

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Sub-category: **Peer Advocate Outreach**

Evaluation

1. Evaluate changes in the provision of peer advocacy services and include an impact/outcome analysis component and an analysis of the cost effectiveness of the model, returning funding to the Buddy/Companion category, if appropriate (=)

Increase Service Capacity

2. Add more peer advocacy services to the integrated services models (+)

Increased Access

3. To increase availability of peer advocacy services after hours and on the weekend (+)

Activity	When	Staffing	Resources
Same as analysis and evaluation of the case management			

4. Hold Peer advocacy services harmless where they are components of integrated service models (-)

5. Cut category proportionally (-)

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Client Advocacy

Sub-category: **Treatment Advocacy**

1. Cut proportionally (-)

Increase Service Capacity

2. To provide more services for newly diagnosed PWAs (+)

Activity	When	Staffing	Resources
Meet with Prevention CTRPN to integrate Treatment advocacy with newly diagnosed PWA's (follow-up to initial HIV diagnosis)	Begin 9/99	AO Staff	$ for providing services or augmenting existing CTRPN activities

Increased Access

3. Link to case management (=)

Activity	When	Staffing	Resources
Already done			

Increase Service Capacity

4. To provide more treatment advocacy services for African American and Latino populations (+)

Activity	When	Staffing	Resources
Look at demographic information about existing Treatment Advocacy services for African Americans and Latinos	2nd qtr, Year 1	Program Staff Clerical Staff	
Look at surveillance data vs. data about # of/who was served - break it down to determine who is eligible for CARE service			
Ensure African Americans and Latinos who are case managed get treatment advocacy - look at utilization			
Augment existing contracts		Program Staff	$ for expanded contracts

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Sub-category: **Treatment Advocacy Cont'd**

Increase Service Capacity

5. To provide treatment focused workshops for newly diagnosed PWA's (UX)

Activity	When	Staffing	Resources
Identify newly diagnosed PWA's through CTRPN and hospitals	9/99	Program Staff	
Evaluate/develop linkages between CTRPN and EIP programs		Program Staff	
Augment EIP contracts to provide treatment focused workshops		Program Staff	$

Technical Assistance

6. To provide training for treatment advocates (UX)

Activity	When	Staffing	Resources
Already doing this activity			

Sub-category: **Benefits Counseling**

Increased Access

1. Link to case management services (=)

Activity	When	Staffing	Resources
See Case Management objective #4			

Sub-category: **Legal/Immigration Assistance**

Increased Access

1. Link to case management services (=)

Activity	When	Staffing	Resources
See Case Management objective #4			

Sub-category: **Money Management**

Increased Access

1. Include in integrated service models (=)

Activity	When	Staffing	Resources
Review money management contract and specify which clients are in both integrated services and money management	2nd qtr, Year 1	Program Manager	
Negotiate so that certain portion of $ goes to integrated services	Year 2	Program Manager	

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Direct Financial Emergency Assistance

Sub-category: **Direct Financial Emergency Assistance**

Increased Access

1. To relax the eligibility restrictions on the types of needs that can be covered under this service (=)

Activity	When	Staffing	Resources
Policy decision	Prior to 3/99	Program Staff Provider(s)	
Implement in new contracts	Implement in 3/99 contracts	Program Staff	
Increase grant amount if pool is widened			

Increased Access

2. To decentralize access to direct financial emergency assistance (=)

Activity	When	Staffing	Resources
Look at the capacity of current providers to expand service hours and/or location	1st quarter of '99	Program Staff	
Survey other providers to determine if they have interest to provide Emergency Financial Assistance		Program Staff	
Survey clients about their experiences with this service and other emergency expenses that should be covered	See needs assessment timeline	Staff conducting needs assessment	Planning Council support $

Increased Access

3. Develop a short-term eviction prevention program (=,+)

Activity	When	Staffing	Resources
Define scope of program	Year 2	Program Staff Providers	$ for additional staffing
Link patients who are in AIDS Emergency Fund who are at risk of eviction to Legal Assistance and Money Management	Year 1	Program Staff	

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Sub-category: **Direct Financial Emergency Assistance Con't.**

Increased Access

4. To create access to direct financial emergency assistance services for the recently incarcerated/released (=,+)

Activity	When	Staffing	Resources
Continued support of development of MOU between Forensic AIDS Project and AIDS Emergency Fund	Ongoing support of existing collaborative relationship	Program Staff	
Ongoing evaluation of utilization and effectiveness		Program Staff	

Increased Access

5. To increase the annual financial limit per client for direct financial emergency assistance (+)

Activity	When	Staffing	Resources
Examine # of patients; analyze cost of living and annual income	9/99		As much $ as desired
Determine eligibility for differing awards		AO Staff Provider(s)	
Build on existing contracts		Program Staff	

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Sub-category: **Food Bank /Meal Delivery**

Enhance Quality Assurance

1. To provide more complete nutrition/meals for the homebound (+)

Activity	When	Staffing	Resources
Conduct needs assessments of the number of people who need delivered meals; Conduct needs assessments of the number of people who need food assistance and are ambulatory	By the end of Year 1	AO - get current POH statistics Consultant - survey	
Evaluate changes in dietary needs		Work with POH's evaluation process	
Evaluate current nutritional composition of meals/food bags and determine deficiencies		Conducted by a group of primary care physicians, dietitians	
Conduct financial analysis re: cost to provide more complete nutrition/meals		POH/DPH Budget Manager	

Increase Service Capacity

2. To develop communal kitchen/cooking facilities (+)

Activity	When	Staffing	Resources
Conduct a feasibility study	Year 3	Consultant	Extensive $

Increased Access

3. To purchase food storage facilities/refrigerators for the marginally housed/homeless (UX)

Activity	When	Staffing	Resources
Research existing refrigeration resources for cost, features, problems, models, liability, safety and security	Year 2	AO Staff (Mgmt Asst)	Internet access
Needs assessment ▪ How many want/need this ▪ Where to locate	Year 1		$ Planning Council Suppt – Needs Assmt

4. Cut nutritional counseling services (-)

5. Cut category proportionally (-)

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Sub-category: **Nutritional Counseling**

Increased Access

1. Link nutritional counseling to treatment advocacy and primary care (including complementary therapies) (=,+)

Activity	When	Staffing	Resources
To contact POH to request that agency be the leader in developing linkages with treatment advocates, peer advocates and primary care providers including complementary therapy	First quarter of '99	Program Staff POH	With = or additional funding
POH to work with currently funded providers of HIV nutrition counseling and complementary therapy contracts to develop and distribute HIV nutrition education material			

2. Cut nutritional counseling services (-)

3. Cut category proportionally (-)

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Adoption/Foster Care

Sub-category: Adoption/Foster Care

Enhance Quality Assurance

1. To develop better services for adolescent placement in foster care (=,+)

Activity	When	Staffing	Resources
Needs assessment	Second quarter '99	DPH Adolescent committee Representative HIV Health Services Representative Health Center #1 "Dimensions" Pgm Rep	$ from Planning Council Support
Investigate capacity for expansion of legal services for children	Second quarter '99	Program Manager	

Day/Respite/Childcare

Sub-category: Adult Day Health Care

Increase Service Capacity

1. To develop a program for people with moderate dementia (+)

Activity	When	Staffing	Resources
Define "moderate dementia" Convene providers (include caregivers/consumers) to come up with the appropriate clinical definition and define parameters for the program	First quarter of '99	Program manager	$ for food and transportation
Explore capacity for expansion of existing adult day health care programs as a resource for developing a separate program this population		Include senior services representative, St. Mary's staff, CMHS program managers, Continuum staff, LHH day program	
Explore expansion of services offered to this population: guardianship, housing, peer advocacy, mental health		Public Guardian staff	
Pilot day program for LHH		AO/Planning staff, LHH staff	
Conduct needs assessment - how many people fall into this category	First quarter of '99		$ Planning Council Suppt –Needs Assmt

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Sub-category: **Children's Programs and Childcare**

Increase capacity/Access

1. Develop a site-based childcare program (=,+)

Activity	When	Staffing	Resources
Conduct needs assessment	1st qtr, Year 1		$ Planning Council Suppt
Conduct grant-writing/Assist CBO in grant writing -Title IV, SPNS	Second half of year 1	AO Staff	

Increase Access

2. To increase childcare access and flexibility, including on-call childcare (=,+)

Activity	When	Staffing	Resources
Conduct needs assessment	1st qtr, Year 1	Consultant	Planning Council Suppt $
Explore increasing capacity of current providers to include on-call childcare	Third quarter prior to 2000-01 contracts	Program Manager	

Enhance Quality Assurance

3. To increase the reimbursement rate for childcare providers (+)

Activity	When	Staffing	Resources
Determine market reimbursement rate	Year 1	Management Assistant Contracts Unit	
Negotiate contractual terms		Program Manager	Additional funding

Increase Service Capacity

4. To develop a voucher a program for childcare services (UX)

Activity	When	Staffing	Resources
See objective #2			
Conduct needs assessment	1st qtr, Year 1	Consultant	$ Planning Council Suppt

Increased Access

5. To make available more vouchers for transportation (UX)

Activity	When	Staffing	Resources
See page 21 #3			

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Sub-category: **Children's Programs and Childcare Con't.**

Increased Access

6. To conduct an inventory of child care potential availability and need (=)

Activity	When	Staffing	Resources
Survey current providers that serve women and/or families to determine past utilization and current child care demand	2nd qtr, Year 1	Program Staff	
Examine current EPI data			

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Program Support

Sub-category: **Technical Assistance**

Technical Assistance

1. To provide technical assistance and training for CBOs (+,UX)

Activity	When	Staffing	Resources
Program evaluation	1st qtr, Year 1	Consultant: Support Center/Kathleen Roe and Assoc./AETC	
Streamline contracting process: presentation	January/February 1999	DPH Committee	
Computer database management		Contractor who has successfully integrated current database w/REGGIE, REGGIE staff	
Harm reduction		CSAS staff	
Contract development	2nd qtr, Year 1	Program Managers	

Sub-category: **REGGIE/ACE**

Technical Assistance

1. To purchase equipment (including computers) for agencies participating in REGGIE (=)

Activity	When	Staffing	Resources
Develop criteria for who is eligible for these funds	End of Second quarter of '99	REGGIE staff	$3,000

Evaluation

2. To conduct an evaluation of the REGGIE project (=)

Activity	When	Staffing	Resources
Develop criteria for evaluation ▪ Timeline ▪ Cultural Competency ▪ Cost-effectiveness ▪ Number of grievances/grievance procedure ▪ Client/provider satisfaction ▪ Use of data	To be completed before Planning Council prioritization process in 1999	Consultant	

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Sub-category: **Transportation**

Increased Access

1. To develop a dispatch system for the system-wide van pool (=,+)

Activity	When	Staffing	Resources
Conduct an inventory of existing van capacity and hours of service (survey)	End of year 1	AO Staff	Internet Access
Research existing dispatch systems (for cost, features, problems)		AO Staff	
Convene a group of existing providers to help develop model		Program Staff	
Conduct and RFP/Alternate Solicitation process		Program Staff Contracts Unit	
Develop contract		Program Staff	$ for contract

Evaluation

2. Conduct an evaluation of current van service providers (=)

Activity	When	Staffing	Resources
Determine parameters for evaluation	Third quarter of Year 1	PC/AO	
Review current data from current providers and develop a report		AO Staff	

Increased Access

3. To investigate the development of a contract with one or more taxi companies to provide transportation for PWAs (=,+)

This objective includes page 17 #5; page 21 #5; and any other transportation voucher related objectives

Activity	When	Staffing	Resources
Talk to SFGH and other departments to determine the terms of their contracts with designated taxi companies	1st qtr, Year 1	AO Staff	
Telephone survey of taxi companies to determine their interest in providing this service		AO Staff	
Discuss with PWAs to determine their experiences with taxi companies		Program Manager or include in Needs Assessment	Planning Council Suppt $ for food if mtg.

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Sub-category: **Transportation Con't.**

3. To investigate the development of a contract with one or more taxi companies to provide transportation for PWAs (=,+) (continued)

Activity	When	Staffing	Resources
Develop the scope of work			
Outcome: Modify existing contract with AIDS Office $ or develop a new contract			

Increased Access

4. To develop an inter-county transportation pool (+)

Activity	When	Staffing	Resources
Determine need for service	Year 1	EMA reps discussion	
Conduct a feasibility study	Year 2	Consultant	

Increased Access

5. To make available more vouchers for transportation (UX)

Activity	When	Staffing	Resources
See page 21 #3			

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Overall

Increased Access

1. Develop an ongoing educational media outreach campaign about available services (=,+)

Activity	When	Staffing	Resources
Create committee (consumers, providers, marketing expert) to plan the creation of a multi-cultural media campaign	1st qtr, Year 1	Contractors Association PWA Caucus Marketing firm SFAF staff DPH staff	$ from Planning Council

Increased Access

2. Incorporate harm reduction principles across all service categories to make services more accessible to active users (=,+)

Activity	When	Staffing	Resources
Agree on harm reduction definition for all service categories	Complete by fourth quarter	All service categories representatives Contractors Association Consumers DPH staff (Margo)	
Establish/conduct bi-annual training for new-hires (either in-house or w/Support Center); can include other issues, such as mental health; trainings should be specialized for specific categories (primary care, housing, etc.); include training for Planning Council	Year 1	AETC/CSAS/AO Management Assistant	$ for trainer, location and materials
Implement into service categories		AO Staff	

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Subcategory: Emergency Housing

Increased Access

1. To expand decentralized access to emergency housing vouchers and shallow rent subsidies through linkages with expanded integrated service networks and at drop-in centers (=,+)

Activity	When	Staffing	Resources
Estimate and assess the implementation of current process	First year	Program managers and service providers	

Increased Access

2. Link emergency housing to integrated services networks and to mobile Case Management and Peer Advocacy Models (=,+)

Activity	When	Staffing	Resources
Already implemented; will assess.	First year	Program managers and service providers	

Increase Service Capacity

3. To provide short-term storage facilities for homeless PWA or those residing in emergency housing (+)

Activity	When	Staffing	Resources
DAH- approx. 25/38 of homeless residents in the DAH program will be HIV+. Storage available at site.	First year	Housing Services	
Recommend: Service be provided through Homeless drop-in center. Refer to Homeless drop-in service group	First year	Program managers and providers	$ for drop in facility

Increase Service Capacity

4. Fund more emergency housing vouchers (UX)

Activity	When	Staffing	Resources
Currently being done with SFAF see #1	First year	Program managers and Svc providers	

5. Cut proportionally (-)

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Sub-Category: **Housing Subsidies: Full and Shallow**

Enhance Quality Assurance

1. To create a reserve fund for minor repairs to units damaged by subsidy tenants (=, +)

Activity	When	Staffing	Resources
Low priority. Will revisit at a later date.	Second year	Program manager	
Cap. Improvement and don't know if can use funds in this way			HOPWA funds

Increased Access

2. To provide better information to those seeking housing, which includes development of a list of landlords who accept subsidies (+,UX)

Activity	When	Staffing	Resources
If more $, then an additional staff person will be added to the DPH-Housing services section to complete this task	First year	Housing Services and providers	More $ for full-time staff person
More of a comprehensive search for all subsidies with a priority for HIV/AIDS individuals and households			

Evaluation

3. To conduct an evaluation of the utilization of services within this sub category, and redirect funds to emergency housing if the services are not being utilized at an appropriate level (=,+)

Activity	When	Staffing	Resources
This is currently being done through homeless monitoring and funds being redirected	First year	Program managers and providers	

Technical Assistance

4. To create an outreach and education program for landlords and clients - landlords: special needs of PWA tenants; clients: what are their rights, how to appeal to landlords, etc. (+,UX)

Activity	When	Staffing	Resources
Refer to #2			

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Sub-Category: Housing Subsidies: Full and Shallow Con't.

Increased Access

5. To increase decentralized access to housing subsidies through the integrated services network and to mobile Case Management and Peer Advocacy models (=,+)

Activity	When	Staffing	Resources
Currently being implemented; will monitor and reassess	First year	Program Mangers and providers	

6. Hold funding for residential subsidies harmless; cut the rest of the category - Housing Subsidies: Full and Shallow - proportionally (-)

Activity	When	Staffing	Resources
Already being done	First year	--	--

Sub-Category: Residential Hospice

Enhance Quality Assurance

1. To provide additional funds to cover increased operating costs (+)

Activity	When	Staffing	Resources
Recommend to HOPWA staff	First year	HOPWA staff and providers	HOPWA Increase

Evaluation

2. Re-evaluate residential hospice versus home health categories (=)

Activity	When	Staffing	Resources
Move home health programs listed under Housing over to the Home Health subcategory – with 2 separate categories	First year	AO	

Sub-Category: Transitional Housing

Increased Access

1. To increase decentralized access to transition housing through the integrated service networks and to mobile Case Management and Peer Advocacy models (=,+)

Activity	When	Staffing	Resources
Needs Further Clarification and definition because transitional pulls off the HWL	Now-First year	--Planning Council	--
To request a waiver from DPH/HOPWA		DPH staff or transitional providers	
Would need to increase the number of beds available for transitional housing		PC/DPH/RA	$$$

PLANNER DISCUSSION ONLY

Sub-Category: **Transitional Housing Con't.**

Increase Service Capacity

2. To investigate master leasing of buildings, sublet with support services (=,+)

Activity	When	Staffing	Resources
Investigation currently underway	First year	DPH Housing Services	General Fund

Increased Access

3. To increase the availability of housing operated using harm reduction philosophies for substance users (+)

Activity	When	Staffing	Resources
Currently underway – connect w/ harm reduction training	First year	Program Staff	

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Sub-Category: Financial

Increase Service Capacity

1. To create supportive services for women and children that are linked to primary care and other necessary and appropriate services (=)

Activity	When	Staffing	Resources
Create additional supportive housing for women and women with children linked to other services	First year	DPH Staff	Need additional resources.

Sub-Category: Practical Support

Enhance Quality Assurance

1. Insure that practical support services are provided within housing facilities, especially within SRO emergency housing (=)

Activity	When	Staffing	Resources
Needs further investigation – assess and adjust for next year's contracts	First year	Existing service providers and staff	

2. Cut category proportionally (-)

Sub-Category: General

Enhance Quality Assurance

1. To provide COLA to housing providers to keep pace with increasing housing costs (+)

Activity	When	Staffing	Resources
Increase Operating Costs for all residential facilities	Next Year and forward	DPH Staff	Increased funding

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Sub-Category: Long/short Term MH Services (Outpatient)

Increased Access

1. To create better integration with other services, including the integrated service networks (=,+)

Activity	When	Staffing	Resources
Change name of sub-category to "Outpatient"	1st qtr, Year 1	--	--
Support integration through contract negotiation –set goal for % of service sub-categories to be provided through "integrated approach" (e.g., out-stationing)	Year 1	Program Staff	
Determine model of service		Providers, PWA, AO Staff	
Through RFP/Alt Sol process, provide MH services on-site, especially at PC sites	3rd qtr, first year	Program Staff	More CARE $
Provide Psych consultation to PC and integrated sites			
Train providers to assess clients for potential MH service needs			
Assessment of which population groups are not accessing outpatient mental health services	2nd qtr, first yr.		
Re-target current providers to serve populations identified above (e.g. immigrant populations, transgender)	2nd qtr, first year	Consultant w/MH work group	$Planning Council Suppt - Evaluation

Enhance Quality Assurance

2. To support better integration of funding sources - including shifting CARE support services and clients to Medi-Cal support when feasible (=,+)

Activity	When	Staffing	Resources
Maximize Medi-cal utilization; shift clients to CMHS, as appropriate	3/99	DPH staff, MH working group	GF for Medi-Cal match
If CMHS single standard of care more fully funded, shift cost of care to CMHS for standard outpatient MH services. Otherwise, through contract negotiations, ensure HIV expertise of MH providers (CMHS), knowledge of other HIV services, linkage to PC and Counseling re: adherence, etc.		AO staff	

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Sub-Category: Long/short Term MH Services (Outpatient) Con't.

2. To support better integration of funding sources - including shifting CARE support services and clients to Medi-Cal support when feasible (=,+) (Continued)

Activity	When	Staffing	Resources
Ensure through contracts that individuals are assessed at intake; those who can pay are doing so (on sliding scale)	FY 99-2000 Contract negotiations	Program Staff	Admin. cost to agencies for billing, collecting $
Ensure CMHS Access services know about HIV services and make referrals.			

Enhance Quality Assurance

3. To provide one-time funds for operating costs for mobile teams (UX)

Activity	When	Staffing	Resources
There are no mobile teams with mental health component (other than crisis unit). No need to fund supplies unless STAFFING is funded			

4. Cut services for the severely mentally ill and transition clients to CMHS supported services (-)

Activity	When	Staffing	Resources
Already happening – CMHS pays psych hospital, txmt, meds, etc.			

Evaluation

5. Evaluate reimbursement cap for services in order to make comparable to Medi-Cal rates (-)

Activity	When	Staffing	Resources
HIV rates are comparable currently to Medical System of Care rates	FY 99-2000 contract Negotiations	Program Managers	---
Through contract negotiation, ensure that HIV rates are in no case higher than Medical Syst. Of Care rates			

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Sub-Category: Long/short Term MH Services (Outpatient) Con't.

Increased Access

6. Link psychiatric case management services to Psychiatric Emergency Services (PES) (=,+)

Activity	When	Staffing	Resources
Assess type of Psych. Case management needed by PES and nature of problem (are clients identified w/in PES as having Case Management in the community?)	3/99	AO Staff, Office of Integrated Care, CMHS staff	More CARE $, REGGIE

Increase Service Capacity

7. To fund on-call, after hours psychiatric services (+)

Activity	When	Staffing	Resources
Expand MH Crisis hours to evening and weekends through RFP	Early First year	Program Managers, Contracts Unit	More CARE $ $200,000 –250,000

Evaluation

8. To conduct an evaluation of the utilization of services within this subcategory and redirect funds if the services are not being utilized at an appropriate level (=)

Activity	When	Staffing	Resources
Evaluate utilization through annual "utilization report" to Planning counsel	First year – Summer '99	Management assistant	

9. Increase category proportionally (+)

Activity	When	Staffing	Resources
Increase $ prop. During contract negotiations	First year, contract negotiations	Program Managers	--
Do we really want to do this? Shouldn't we put $'s out –to –bid for integrated services, more crisis services, psych care, management, etc.?		Staff for RFP	More CARE $

10. Cut Category Proportionately (-)

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Sub-Category: **Psychiatric Consultation**

Increased Access

1. To increase psychiatric assessments, with triage, at more locations, and with more linkages. Possible settings include primary care, treatment facilities, SROs, shelters, etc. (+)

Activity	When	Staffing	Resources
See Mental Health outpatient services discussion With additional CARE $, issue RFP or augment existing contracts	First year	AO and service providers	Staff time and commitment, $55 - 75k per site/staff added: $200-250,000
Evaluate use of Psych assessment in current integrated services: is it being used, integrated, what are the outcomes? Assess the impact of linkages between integrated svcs on long-term mental health services. Determine if people are being appropriately referred to non-crisis services		Consultant - Evaluator	Planning Council Suppt Evaluation $

Sub-category: **Crisis Services**

1. Increase Services Proportionally (+)

Sub-category: **Residential Care**

Increase Service Capacity

1. To fund/create a residential facility for PWAs with moderate dementia/cognitive impairment (+)

Activity	When	Staffing	Resources
Assess need to determine size of facility (# of beds, staffing level).			
Create workgroup to coordinate.			
Talk to St. Mary's re: discharge volume, placement problems			
Investigate buying beds in existing facilities to meet need.			
Investigate use of HOPWA $ to help acquire/develop facility.			
Issue RFP	1st qtr, Year 1	AO	CARE $ Staff time

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Sub-category: **Residential Care Con't.**

Technical Assistance

2. Provide training for service providers on dementia/cognitive impairment (+)

Activity	When	Staffing	Resources
Ask providers who provide services to those with dementia/cognitive impairment to send program promotion information to other providers on services available	First year	Service providers Program Managers	
Ask AETC to put together training on dementia for providers	Jan/Feb 1999	AO, AETC, Service providers	

3. Cut inpatient psychiatric beds (-)

Activity	When	Staffing	Resources
Assess what this service is, what utilization is, who is being served, appropriateness of cost, etc., before cutting, look at availability/capacity of community resources	1st qtr, Year 1	AO, Office of Integrated Svcs, rep from 4P	staff
Who determines how beds are filled?		Program Manager	
If cut – cut contract MultiDiagnosis Unit			

4. Increase category proportionally (+)

Activity	When	Staffing	Resources
Increase contracts proportionally	1st qtr, Year 1	AO	CARE $, staff time
Better to target specific dementia programs described in other sections. This should be lower priority for increased funding.			

DRAFT FOR DISCUSSION ONLY

Substance Abuse

Sub-Category: Residential Long-term

Evaluation

1. Combine with residential short-term category and create variable length of stay services, with analysis of need, and limit based utilization (=)

Activity	When	Staffing	Resources
Depends on creation of more housing, increase $ for satellite housing	*Now*-First year	AO, CSAS, etc.	CSAS, McKinney, HOPWA, CARE $
Create variable length of stay programs and combined categories	DONE	DONE	--
Analysis of need: actual length of stay; How much of need is housing rather than residential SA treatment?	*Now*- First year	AO, CSAS, providers,etc	Staff time
Create more transitional housing, with after-care services		Program managers, Housing Center, Development, CSAS	CARE, other housing $ (HOPWA, McKinney)
Create more emergency/transitional housing, with after care services		"	"

Increased Access

2. Create more services for women with families (keeping children with them) (=)

Activity	When	Staffing	Resources
Determine area(s) of service gaps and determine model of service	1st qtr, Year 1	Providers workgroup, AO staff	Needs assessment
Coordinate with TOD $ for services; Joint planning, joint RFP		AO, CSAS, Planning Council	
Issue RFP, w/ more $ (HHS/CBC initiative includes $ -- ensure SF providers apply)	3/99	AO	CARE $, staff time
Link with other services: CSAS, family services, etc.			

DRAFT FOR DISCUSSION ONLY

Sub-Category: Residential Long-term Con't.

Technical Assistance

3. To provide training for service providers on integrating harm reduction principles into service provision (=,UX)

Activity	When	Staffing	Resources
Agree on harm reduction definition for all service categories	Complete by fourth quarter	All service categories representatives Contractors Association Consumers DPH staff (Margo)	
Establish/conduct bi-annual training for new-hires (either in-house or w/Support Center); can include other issues, such as mental health; trainings should be specialized for specific categories (primary care, housing, etc.); include training for Planning Council	Year 1	AETC/CSAS/AOM anagement Assistant	$ for trainer, location and materials

Increased Access

4. To create better linkages of providers into networks of care (=)

Activity	When	Staffing	Resources
Encourage communication between SA providers and HIV providers through integrated service providers working group	First year During contract negotiations	Program managers	Staff time
Continue with HIV treatment training for SA providers. Make mandatory for SA staff	--	--	--

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Sub-Category: **Residential Short Term**

Increase Service Capacity

1. To redirect some funds into a residential harm reduction model (+)

Activity	When	Staffing	Resources
Agree on harm reduction definition for residential services		Contractors Consumers DPH staff (Margo)	
Issue RFP for new model of residential care, starting with harm reduction. Investigate joint funding with TOD	2nd year	AO, CSAS	CARE$, TOD$

Evaluation

2. To evaluate the cultural appropriateness of programs and to provide training where needed (=,+,UX)

Activity	When	Staffing	Resources
Work with other DPH divisions with on-going programs, especially TOD, as there is no need to recreate the measures and standards already developed	*Now*-First year ongoing	AO, CSAS	minimal

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Sub-Category: **Residential Short Term Con't.**

Increased Access

3. To encourage more linkages between jail and community-based services (=,+)

Activity	When	Staffing	Resources
Assess need for linkages – include incarcerated in needs assessment	98-99	AO, consultant	CARE $, staff time
Use contract negotiations/ MOU's to encourage better linkages. Coordinate with Treatment on Demand services in the jails. Work with Forensic AIDS Program to ensure working with SA treatment programs	First year Contract negotiations	AO, programs, CSAS	Staff time
Assess follow-up on clients, and follow through on linkages OUTCOMES	2nd year	AO, consultant?	
Set up work group? Advisory to Planning council for next priority setting		AO, Council	

Increase Service Capacity

4. Create more services for MSM/IDU'S (+)

Activity	When	Staffing	Resources
CSAS RFP already out – will increase services	--	--	CSAS
HHS initiative includes $ for MSMs; ensure SF providers apply for $	--	--	--
Support continuation of existing services for gay men especially speed users and youth		AO, CSAS	CARE $
Need for transitional housing (with harm reduction model) – increase services. Issue RFP w/joint funding streams	1st qtr, Year 1	AO, CSAS	CARE $

Enhance Quality Assurance

5. To provide furnishings for residential programs (UX)

Activity	When	Staffing	Resources
Costco? Get a list of furniture needed and purchase centrally to reduce costs	2/00	AO	CARE $
Appropriate use of unexpended $			

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Sub-Category: Out Patient Counseling

Increase Service Capacity

1. Develop programs as alternatives to drug use - recreational, etc. - especially for youth (+)

Activity	When	Staffing	Resources
Incorporate with harm reduction strategies in other services, not solely substance abuse	*Now*-First Year Do research now, but this is a low priority item	Service Providers and HIV services	Depends on how program is defined
Connect to Youth Residential Program? Case Management Program? Support Services?			
Put Service out to bid			
Shanti and Walden have programs… *Need clarification on the scope of the programs*		Program Managers	

Increase Service Capacity

2. To develop more services for transgender PWA's (+)

Activity	When	Staffing	Resources
Conduct Needs Assessment	1st qtr, 1st year	Consultant	
Convene working group to develop model	3/99	AO Staff/Consultant	
Create more services – $ out to bid		--	$

3. Hold outpatient services harmless (-)

Activity	When	Staffing	Resources
Move detox programs out of outpatient services subcategory and relocate to detox subcategory	*Now*-First year	--	--

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Sub-Category: Out Patient Counseling Con't.

Increase Service Capacity

4. To create a drop-in center, which includes outpatient counseling as one of the services offered (+)

Activity	When	Staffing	Resources
Drop-in service connected to HIV services integrated model—connected to harm reduction rec. center: emergency storage, showers/laundry, open kitchen.	Second year	Planning group	$, competitive bid
Could do competitive bid, but better connected to integrated model			

Increase Service Capacity

5. Make available child care vouchers, which can be utilized while PWAs are receiving outpatient care (UX)

Activity	When	Staffing	Resources
Conduct needs assessment	First half of Year 1	Consultant	Planning Council Suppt $
Assess the necessity of voucher how are we are not meeting needs?	First half of Year 1	AO staff, service providers, DHS, CARE Council Reps	

Sub-Category: Detox

6. Encourage more utilization of alternative detox services, such as acupuncture (+)

Activity	When	Staffing	Resources
Need clarification. Should this go under training? Should client advocates know more about it? Are there logistical obstacles?			

Sub-Category: Overall

1. To coordinate substance abuse services across funding streams - working with CSAS' Treatment on Demand to leverage services, combine services, combine funding streams, and plan for the system as a whole. Linkages should be made to housing and other services funded elsewhere (especially youth services) (=,-,+)

Activity	When	Staffing	Resources
HIV Health Planning Council, CARE council, TOD should continue to meet; quarterly divisional meetings, Integration of care	First year	Office of Integrated Care	--

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UPDATE ON IMPLEMENTATION OF '98 PROPOSED PRIORITIES & ALLOCATIONS

Health Care

Sub-category	Change	Rationale for Change	Rationale	Severe Need (Priority Population)	Target Services	If more $	Process Used & Implementation Status	Outcome
Primary Care	$0	($252,876) cut from primary care due to underutilization. +$252,876 move staff from pharmaceutical into this line	($252,876)	PWAs w/ OI's, Multiply dx, homeless not accessing treatment	Linked services to substance abuse, mental health, case management, multidisciplinary mobile services		Dollars cut from Primary Care budget; dollars for pharmacy staffing moved to PC budget. Severe need pop specified in RFP and Alt Solicitation. Integrated, multidisciplinary service models developed through RFP process with PC at center of service system.	Budget changes implemented. New models developed but too early to evaluate impact.
Dental	$0			PWHIV without or inadequate insurance	$380,000 goes to decentralized, mobile, on-site dental services accessible for people without adequate dental insurance, linked to Prim Care clinics.		Dollars were allocated to decentralized service. Service was included in RFP with successful bids for centralized and decentralized programs.	Centralized svr ongoing; decentralized began Oct 1, 1998.
Pharmaceutics	($252,876)	Move pharmaceutical staff into primary care. Keep this line drugs only.	Pay for drugs only - decrease professional services, move costs to primary care	Zero to low income who are not covered by MediCal, ADAP, HMO's.		Reserve in case of added ADAP need	Pharmaceuticals separated from staffing in budget. Non-ADAP drugs augmented with add dollars.	Pharmaceuticals consolidated in budget. More $'s allocated for non-ADAP drugs. In Sept. 1998 a large no of new drugs were added to ADAP formulary. As result, there may be savings to this sub-catg. in future.
Comp Therapy	($115,736)	Based on utilization, need has been sufficiently met	Based on utilization, need has been sufficiently met				Funding reduction was made.	Fewer dollars spent on this service.
Home Health	($481,523)	Based on utilization and projected declining need	Based on utilization and projected declining need	Homebound, multiply diagnosed	Decrease hospice level care, create mobile programs at SRO hotels that go where client is	If more $ restore some services	Funding reduction was made. Some services (Attn. Care) were restored due to add $'s. Svrs provided by same provider but dollars adjusted by modality based on community need (e.g, reduction in Home Infusion). Demand for hospice support has increased due to opening of new facility (Maitri). The AO is currently assessing need for supplemental $'s for Resid Site Care srvs for FY 98-99. In add, AO has worked with Resident providers & VN&H to improve home hlth services for residential programs, including contract changes. Mobile programs at SRO hotels held level (no increase) due to reduction in funding.	Difficulty in meeting need for Residential Site Care staffing as result of funding reduction to sub-category and new service demands.

Sub-category	Change	Rationale for Change	Rationale	Severe Need (Priority Population)	Target Services	If more $	Process Used & Implementation Status	Outcome
Vision Impair	$0						Providcr terminated contract and no new contractor sought. There is a decreased need for this service due to new txs and fewer CMV retinitus cases.	Some services still available from provider at no cost to CARE.
Subtotal	($850,135)							

Implementation Update in Italics:

Goals and Outcomes:

Proposed Allocations Linked to substance abuse and mental health, mobile team that goes to SRO's *(RFP was developed for Integrated Service models and new Integrated Services begain in Fall of 1998.)*

Incorporate Treatment Advocacy. *(Incorporated into RFP for Integrated Services and for Case Management. New programs available for clients in Fall of 1998.)*

Develop specific programs for primary care access and treatment modalities for Younger Gay Men and People of Color, Women and Children (on-site childcare). *(Specific primary care programs were developed for POC and women. No response received to RFP specific to primary care for younger gay men. No additional dollars were provided for on-site childcare services at primary care sites. Childcare is already under contract with two community providers which provide both in-home and some on-site childcare. Several primary care programs targeting women also provide childcare on-site, e.g., UCSF Women's Specialty Clinic, UCSF Pediatric AIDS Clinic, and Lyon Martin. Childcare at these sites is supported with non-CARE dollars.)*

More proactive use of emergent therapies (i.e. resistance testing). *(No additional funding provided to pay for this service. Clinical usefulness of resistent testing still uncertain.)*

Challenges

- Increase access to primary care *(Achieved through RFP for Integrated services and addition of Peer Advocacy and Treatment Advocacy services.)*
- New treatment therapies to those populations who are receiving unequal treatments (substance abusers, mentally ill, etc.). *(Increased access through new objectives in Sub Abuse contracts linking clients to Prim Care and objectives in other contracts requiring name of MD, date of last visit, and coordination between services.)*
- Create and augment linkage with all other CARE funded categories. *(See above)*
- Develop triage and outreach programs linking clients to primary care, specifically substance abuse, mental health and housing. *(Creation of Peer Advocacy programs)*
- Provide low cost Community Health-based dental care for PLWHIV. *(Achieved through RFP for decentralized dental services.)*
- Dentists must demonstrate clinical expertise in treating HIV oral related and dental problems. *(Required in RFP)*
- Pharmaceutical services in all other categories should be consolidated into this category. *(Achieved in budget.)*

Linkages to Other Available Resources

AIDS primary care into the General Primary Care Services of the DPH.

Linkages to other CARE Programs

Strong linkage with Substance Abuse, Mental Health, Case Management, Dental, Drug Reimbursement, and Health Insurance *(See above. ADAP enrollment sites are being increased to include more CBO's. Some Primary Care contracts now include screening for substance abuse problems.)*

Housing

Sub-category	Change	Rationale for Change	Rationale	Severe Need (Priority Population)	Target Services	If more $	Process Used & Implementation Status	Outcome
Emergency Vouchers	$0	change wait list criteria to prioritize very poor and homeless.	1500 on wait list--service need not addressed	Homeless, multiply diagnosed, $0-HUD 50% low income (10k/ann),	More geographically dispersed access to emergency housing system		Housing provider contracts changed to prioritize very poor (<$10K/yr) and homeless. RFP for Integrated Services required that emergency vouchers be linked to permanent housing (subsidies) to ensure long-term housing stability.	Some clients "falling through cracks." Vouchers not being fully utilized for a variety of reasons. Provider feedback needed.
Permanent-Subsidies, Shallow rent	$0	change wait list criteria to prioritize very poor and homeless. If we get more money add $2M to subsidies		PWA disabled, women with dependents, GA, SSI, SSDI	Services prioritized, increased subsidies Low income (under 10K/ann income eligible)	$2,000,000	Housing provider contracts changed to prioritize very poor and homeless. Additional dollars added for shallow subsidies. Through RFP, subsidies consolidated into one program for cost savings.	Most in need (lowest income) prioritized. More money available for subsidies.
Residential Hospice	$0	Redefine Hospice to sub-acute care for the chronically ill, prioritize people with dementia		People with HIV and dementia	Temporary care for the chronically ill		The AO does not hold contracts with hospice facilities other than for home health svrs. The home health contract was changed to include chronically ill. The Redevelopment Agency is supporting programs providing sub-acute care for the chronically ill which prioritize people with dementia.	Hospice programs are serving chronically ill patients and people with dementia.
Transitional	$0	create harm reduction models		Active users	Create continuum to move into permanent housing, harm reduction models.		Contractors are asked to address harm reduction in their contracts. Rafiki House & Arc of Refuge are transitional program. These programs incorporates harm reduction principles into their service delivery systems but more training and technical assistance may be needed.	Harm reduction is incorporated into programs but more training and T.A. may be needed by providers.

Housing Continued...

Sub-category	Change	Rationale for Change	Rationale	Sevère Need (Priority Population)	Target Services	If more $	Process Used & Implementation Status	Outcome
Support Services: Money Mgmt, Benefits Counseling, Eviction Prevention	($14,596)	Based on under-utilization	Based on under-utilization		Link all services to primary care, food, substance abuse, mental health treatment options.		Reduction to Money Mngmt was made to budget. Additional dollars were allocated for Benefits Cnsl and awarded through Alt Solicitation (see Client Advocacy). Eviction prevention being done by ALRP (contract change). Money mngmt. services were centralized with a single provider through RFP.	Fewer dollars avail for Money Mngmt and more for Benefits Cnsl.
Practical Support using Peer Advocates	$100,000	Add new $	Moved from Buddy/Companion		Peer Advocate Model		Dollars added and included in RFP for Peer Advocates. Practical Support was combined with Peer Advocacy/Outreach in RFP because of similar title, function, and staffing requirements.	Peer Advocacy is funded but amount of practical support services (vs outreach & other functions) cannot be measured.
HOPWA 97-98	($857,947)		Keep in HOPWA				Programs retained or rolled-over to CARE from HOPWA were incorporated into CARE budget.	
HOPWA 98-99	($1,051,186)		Keep in HOPWA				Programs retained or rolled-over to CARE from HOPWA were incorporated into CARE budget.	
Subtotal	($1,823,729)							

Implementation Update in Italics:

Goals and Outcomes:

- House 1500 people off the CHIPS list by the end the next CARE funded year using CARE, HOPWA and other available resources. *(Extremely tight housing market in SF prevents full realiziotion of this objective.)*
- Create housing continuum so people can access the level of housing they need. *(Per the RFP which included Housing services, a continuum from emergency vouchers to permanenet subsidies are avoiloble In addition, for individuols who have been stobilized in housing but need ossistance, the SFDPH hos secured funding for 41 portiol rent subsidies. Another 86 shallow rent subsidies have been made availoble through CARE funding for clients of Integrated Service providers. Also as part of RFP, the full subsidy progrom was consolidoted so thot individuols can access permanent housing with minimum program confusion.)*
- Create stable housing resources for people with HIV using HOPWA capital reserves. *(Redevelopment Ag stotes that all dollars ore currently committed, especoilly following recent NOFA. Two year subsidy reserve has been reduced to 1 yeor, to be used in the event that HOPWA is defunded.)*
- Redefine Hospice to temporary care for the chronically ill. *(See Health Care/Hospice)*
- Make more use of HOPWA subsidies for those who qualify. Use CARE to concentrate on most needy first. *(Eligibility criterio for CARE subsidies changed in controcts to serve lowest income individuols, i.e., homeless, 50% of very low income. Redevelopment Ag stotes thot goal for subsidies has been increosed from 350 to 400. As of 10/29/98, there ore 291 HOPWA subsidies filled with 80 individuols seeking apartments. Lack of housing in SF continues to be major obstocle to use of subsidies.)*
- Create new income eligibility requirements for housing resources through CHIPS. *(Achieved through changes to housing provider controcts.)*
- Serve those most in need first (refer to severe need target population). *(Achieved--see above)*

Challenges

Address the needs of Homeless PWA's *(Homeless with AIDS are identified as the torget populotion in Rentol Assistance/Subsidy contracts.)*

Create stable housing resources using Harm Reduction models. *(The SFDPH Housing Division believes thot the mojority of residentiol housing sites are successfully utilizing horm reduction models for their respective clients. These programs include Hazel Betsey, Planetree Housing Progrom, Derek Silvo Community, Restoration House, and others.)*

Make provisions for people who fall out of the system - evicted, out of compliance etc.

Linkages between transitional and permanent housing and changes in disability criteria. *(The SFDPH Housing Division indicates thot the only current linkage between transitionol and permonent housing is the Rofiki Program which ossists in further stobilizing individuals, who ore then prepored for longer term permonent housing ot the Stinson ond Precito sites, as vonconcies occur.)*

Linkage to transitional housing for transgenders

Linkages to Other Available Resources

Work with other disabled programs to ensure housing.

HOPWA, McK.

General Fund and re-entry program.

Linkage to other CARE Programs

Prim Care (Home Health), Case Management, Mental Health and Sub Abuse Tx services. *(Achieved through Integroted Services controcts.)*

Food

Sub-category	Change	Rationale for Change	Rationale	Severe Need (Priority Population)	Target Services	If more $	Process Used & Implementation Status	Outcome
Food Bank/Meal Delivery	($200,000)	Create income eligibility to prioritize low income and homebound first	Does not focus on populations of severe need, projected availability of other funding sources	Low income, homebound, disabling HIV	Re-direct entire category to focus on very low income under $10k/ann, develop means test to ensure money goes to those most in need		Reduction made in budget but some dollars restored with add CARE $'s. Contracts stipulate focus on very low income and use of means test to ensure those in most need are served.	Most needy clients (lowest income) served.
Nutritional Counseling	$0							
Congregate Meals	$0							
Food Solicitation								
Subtotal	($200,000)							

Implementation Update in Italics:

Goals and Outcomes:

Develop means testing based on income, severity of illness and targeting homebound for priority food services. *(Achieved through contract language.)*

Linkages to Other Available Resources

Food Bank with other community food resources. Begin reintegrating funding streams.
Other funding streams are episodic.

Linkages to other CARE Programs

Case Management and Peer Advocacy
Other Community based resources.
Primary Care

Mental Health

Sub-category	Change	Rationale for Change	Rationale	Severe Need (Priority Population)	Target Services	If more $	Process Used & Implementation Status	Outcome
Long/short term psycho-therapy	($850,000)	Doesn't focus on populations of severe need. Re-direct to crisis, triage and short term services focused to Multiply dx, youth, women, people of color, homeless, children and AIDS dementia		Multiply dx, youth, women, people of color, children, homeless, severely mentally ill, AIDS dementia assistance	Cut long-term, but do more analysis regarding who is using long term services. Re-direct to crisis, triage, and short-term	Expand youth and pre-crisis services, develop prevention and early intervention for HIV Dementia	Reduction was restored w/roll-over funds by Plan Cnsl through 2/28/99. Analysis (survey) was conducted that demonstrated significant proportion of cls currently served meet severe need criteria. Some contractors have changed their contracts to reach more special need pops (including youth), integrate services, focus cnsl on HIV and Tx-related issues & incr dementia screening/outreach to providers. Other changes now in process: Contracts contain utilization review mech to ensure control over ongoing tx, Medi-Cal Work Group meeting to eliminate Medi-Cal from CARE, incr coord w/CMHS.	No fiscal change until FY 99-2000 when GF will support services. Increased collaboration with other providers to make svrs more accessible and coordinated. Too early to evaluate impact.
Psych consult	$0	Triage linked to Prim Care and Sub Abuse Tx			Triage linked to Prim Care and Sub Abuse Tx		RFP for Integrated Services required Psych Consult for triage and linkage. No other changes seen to be necessary.	Integrated Services have not yet been evaluated.
Crisis	$0							
Residential Care	($350,000)	Underutilization	Cut Chateau Agape		Develop harm reduction models for triply diagnosed. More in-home, "one stop" models		Program defuned.	Dollars no longer spent on this service. HIV+ psych pop needing residential care are served by CMHS.
Subtotal	($1,200,000)							

Implementation Update in Italics:

Goals and Outcomes:

- Triage to link primary care, substance abuse, case management. *(See above.)*
- Develop Harm Reduction models for triply-diagnosed. *(Not addressed during implementation.)*
- Allow use of psych meds. in Substance Abuse Treatment programs. *(This is not a Mental Health recommendation.)*
- Develop more in-home and "one-stop" models. *(See above.)*
- Create a Mental Health drop-in center for PLWHIV with mental problems including depression (Staff includes Case Managers and Peer Advocates). *(Funding not provided to implement this recommendation.)*
- Develop early intervention programs for HIV Dementia. *(Funding not provided to implement this recommendation.)*

Linkages to Other Available Resources

CMHS for ongoing and long term psychiatric treatment. *(The AO is working with CMHS and providers to transition Medi-Cal patients to CMHS. Clients needing residential and other specialized mental health services are referred to CMHS services.)*

Linkages to other CARE Programs

Primary Care, Substance Abuse, Rehabilitation: Dementia Care, Hospice and Home Health.

Sub-category	Change	Rationale for Change	Rationale	Severe Need (Priority Population)	Target Service	If more $	Process Used & Implementation Status	Outcome
Residential Long term	($45,000)	Under utilized service, re-direct some services to harm reduction	Under utilized, decreased demand. Most clients looking for housing not long term residential		Harm reduction		Funding reduction implemented.	
Residential Short term	$0	Re-direct some services to harm reduction			Linking to Prim Care & Sub Abuse Tx, Harm reduction model		Contract objectives have been developed that address linkage to Primary Care.	
Methadone	$75,000	Large waiting list, high demand create model for homebound	Large waiting list, high demand	Homebound		Increase Meth tx slots	Additional svrs were bid through Alternative Solicitation..	Contract, which will increase tx slots, is currently under development.
Outpatient Counseling	($50,531)		Based on utilization		Link to Prim Care & mental health, case management, youth, incarcerated. Triage, integrated services, "one stop."			
Detox	$0			Multiply dx, homeless clients	Take $250K unencumbered and use for harm reduction & services linked to Primary Care.		$250K budgeted for CSAS/Baker Places post-detox program was not redirected pending start-up of this new program.	MOU is in development with CSAS for Baker Places' new 7th Street program. Facility opened September 1998.
Subtotal	($20,531)							

Implementation Update in Italics:

Goals and Outcomes:

- Link programs to primary care. *(All substance abuse contracts now include standard process and impact objectives for each mode of service. These objectives include development of linkages to other services such as Primary Care. In addition, contracts now require that client records reflect the name of the primary care provider and the date of the last visit. Client referrals must be documented--both that the referral was made as well as that follow-up procedures are in place to ensure that the client received the referred service.)*
- Develop specific models for AIDS/HIV related substance abuse problems. (*There have been major provider changes with respect to admission criteria, HIV and pain medication management and policies, as well as changes in staff patterns that better meet the needs of HIV+ clients, e.g., use of multi-disciplined teams.)*
- Develop models based on Harm Reduction as well as abstinence and 12-step. *(Many harm reduction practices are in place. There have been specific changes made in contracts, esp outpatient services, to ensure that clients receive information, support and assistance in examining impact of sub use without making a "total abstinence treatment" commitment to the program. AO staff feel that harm reduction needs to be incorporate into other services in addition to Sub Abuse, including Primary Care, Mental Health, Housing, etc.)*
- Develop programs using psychiatric and pain meds in Substance Abuse Treatment programs.
- Develop alternatives for Methadone Maintenance programs for homebound PWA's.

Challenges

- HOPWA dollars subsidize Residential Treatment facilities.
- Getting other funding streams to pick up non-HIV specific substance abuse services.

Linkages to Other Available Resources

Integrated services (one-stop) *(Substance abuse treatment was not included in the RFP for Integrated Services but respondents were required to explain how their program would assess, provide "pre- substance abuse treatment" services, and link to sub abuse services.)*

CSAS and other housing services including HOPWA.

SAMSA services

Linkages to other CARE Programs

Develop linkages with Housing, Mental Heath, Case Management, Primary Care and Treatment on Demand *(See above. In addition, many of the HIV sub abuse providers are also Tx on Demand providers.)*

		Rationale for Change	Rationale	Severe Need (Priority Population)	Types of Services	If more $	Process Used & Implementation Status	Outcome
Case Management	($1,030,000)	Many people have multiple case managers, shouldn't be agency based but client based. Focus on multiply dx, homeless. Create roving, on-site, multi-lingual services linked to primary care, sa and mental health. Some cut based on under-utilization. $460K moved to Peer Advocate/ outreach.	Many people have multiple case managers, shouldn't be agency based but client based. Some cut based on under-utilization. $460K moved to Peer Advocate outreach.	Multiply diagnosed, homeless, those out of treatment.	Roving -- on-site, triage, function linked to other services Not stand alone case management Multi-lingual		Budget: Reduction was implemented but some dollars were restored with add money. Pop and Service: This service was competitively bid in RFP and reshaped to reduce duplication and ensure client based (not agency based). Funding for Housing CM was put out-to-bid in RFP as CM dollars. Peer Advocacy and Tx Advocacy are now integrated with Case Mngmt services. Integrated Services includes focus on multiply dx & homeless as well as creating roving, on-site, multi-lingual services linked to primary care and other srvs. CM for youth was bid through Alternative Solicitation and awarded to community provider.	Reduction in dollars available for Case Mngmt (some redirected to Peer Advocacy). Major change in CM system but impact yet unknown. Youth Case Management contract is currently in development.
Peer Advocate Outreach	$460,000	To link those out of treatment to system of care, targeting youth, women, those not in treatment.	To link those out of treatment system of care	Youth, women, those not in treatment	Mobile, Street-based, on-site		Budget: Dollars added and put in RFP for Peer Advocates. Peer Advocacy/Outreach was combined with Practical Support in RFP.	Peer Advocacy is funded but amount of outreach & other functions (vs practical support) cannot be measured.
Subtotal	($570,000)							

Implementation Update in Italics:

Goals and Outcomes:

Provide Case Management only for those who need it, when they need it. *(See above.)*

Provide AIDS specific case management, particularly treatment access. *(See above. Peer Advocacy and Tx Advocacy integrated into Case Management services.)*

Reduce redundant, agency based multiple Case Managers *(See above. The wide-spread use of REGGIE may create a mechanism for ensuring that each client has only one CM.)*

Link case management to needs and services, not to populations. *(Some population based CM programs are still in operation due to language and cultural needs.)*

Translation moved and integrated into case management. *(Achieved through changes in contract.)*

Challenges

- Develop and implement HIV Case Management standards. *(Achieved in prior years with "Making the Connection: Standars of Practice for Client-Centered HIV Case Management.")*
- Develop periodic Case Management Review and Assessment.
- Case Managers must demonstrate AIDS/HIV specific knowledge and must be able to confront a myriad of HIV related issues and prove successful advocacy on behalf of their clients. *(AIDS Office contracts now require in all contracts, not just Case Management, that all non-medical direct service staff must attend or register for the HIV Treatment Education Certification program.)*
- MH and SA case management should not be category specific, but work to integrate client into a full system of care. *(While contract language ensures that MH and SA case managers assess for and link clients into a full spectrum of needed services, there is currently no way of ensuring that this CM functions as the single CM for the client*

Linkages to Other Available Resources

CMHS, CSAS and Human Resources.

AETC to train case managers in tx advocacy. *(See above)*

Linkages to other CARE Programs

Peer Advocacy, Housing, Mental Health and substance abuse services. *(See above. Ccontracts now require that client records reflect the name of the primary care provider and the date of the last visit. Client referrals must be documented--both that the referral was made as well as follow-up procedures are in place to ensure that the client received the referred service.)*

Other Support Services

Sub-category	Change	Rationale	Severe Need (Priority Population)	Target Services	Process Used & Implementation Status	Outcome
Client Advocacy						
Tx/Clin Trials Advocacy	$0	Increase services to reach populations not accessing treatments including women, POC, homeless, triply dx	Homeless, triply diagnosed, People of Color, Women and those not receiving treatment or aid. Prioritize extremely low income and multi dx		Tx Advocacy incorporated into Case Mngmt and Peer Advocacy. All non-medical service providers are required to be trained through HIV Tx Education Certif Program. Tx Adv. incorp into Integrated Svrs. to incr assess for severe need populations. Comm Events defunded. Benefits Cnsl funding augmented through Alt Solicitation.	Too early to evaluate impact of changes. Benefits Counseling augmentation contract is currently in development.
Benefits Counseling	$60,000					
Legal/Imm Assistance	$0					
Community Events	($69,189)					
Money Management	0	Not priority service				
Subtotal	($9,189)					
Buddy Companion		Doesn't reach populations with severe need. High cost for volunteer services, most $ goes towards training and admin. Peer Advocacy and housing support services will be taking on.	Populations hardest to reach or not getting service	Focus on practical support, link peer advocacy	Emo/Pract Suppt srvs and training defunded. Peer Advocacy services initiated through RFP process to reach severe need pops.	Too early to evaluate impact of changes.
Emo/Prac Support	($751,572)					
Training	($47,364)					
Subtotal	($798,936)					
Adoption/Foster Care	($30,915)	Based on under utilization	Assess need for adoption vs. unmet need for childcare		Funding reduction implemented. Assess of need for adoption and childcare not yet done.	Assess of need for adoption and childcare included in Implementation Plan for 1999-2000.
Day/Respite/Childcare			Linked to programs, on-site Day care for people with moderate dementia	On-site Care	No additional dollars provided for new programs. Day care for people with moderate dementia and on-site childcare already funded.	Assessment included in Implementation Plan for 1999-2000.
Adult Day	0					
In Home Respite	0					
Childrens' Programs & Childcare	0	Cut under-utilized program and move to on-site care.				
Subtotal	0					
Planning Council Support				Staff support, Council participation, and assessments	New contract developed for Planning Council support.	Planning Council receiving support.
Planning Council Support	($57,158)					
Grantee Staff	($158,442)					
PC Staff and Support	$250,000					
Subtotal	$34,400					
Program Support		Use training funds for program below (training and education of treatment providers and peer advocates). If more money, give $180,000 to REGGIE	New treatment education to providers	Treatment education	Provider training and TA was defunded. REGGIE funding was reinstated by Plan Cnsl at lower level than FY 97-98. New treatment education and certification program was put out-to-bid and implemented.	Too early to evaluate impact of changes. Feedback on HIV Tx Educ & Certif program has been very positive.
AAMAP	($85,846)					
REGGIE/ACE	($242,359)					
Training & Educ	$150,000					
Subtotal	($178,205)					
Transportation	$0			Dispatch system	Dispatch system is currently utilized by the single funded provider of this service.	
Direct Fin Emergency Ass.	$100,000	97 unexpended funds would go here first up to $500,000			This contract has received additional dollars.	Provider was able to increase amount awarded per client per year for emergency financial assistance.
Total	($882,845)					

Implementation Update in Italics:

Other Support (Continued)

Client Advocacy

(The following directives are being addressed by Peer Advocates and Tx Advocates as part of Integrated Service models and Case Management programs.)

Treatment Advocacy

Continue to support targeted treatment advocacy for underserved populations including African Americans, women, impoverished clients, and MSMIDUs.
Links with testing sites, PEP program, and Options program.
Better linkages with primary care providers and case managers
Responsible for training all Peer Advocates
Responsible for inservices for clients in residential or outpatient substance abuse treatment programs.

Benefits Counseling

Aid for people leaving work due to HIV-Disease. *(Included as requirement in Alternative Solicitation and in renewal contract language.)*
Getting people on SSI, SSDI etc. Link with Insurance and Drug Reimbursement and Case Management services. *(Currently implemented in contracts.)*
Services for both PWAs out of work and those going back to work. *(See above)*
Is benefits counseling different for people with other disabling disease (e.g. cancer)?

PEER Advocacy

(Peer Advocacy was incorporated into the RFP for Integrated Service programs and Case Management programs.)

Hire PLHIV's as Child-care workers for women PWA's for appointments, Peer Advocates for Case Management Professionals, Buddy/Companion support services and Planning Council Staff. *(Implemented in Planning Council Support category. Included in RFP but outcome yet to be assesed for other categories.)*
Utilization of PWHIV in outreach activities. *(Included in RFP. Outcome yet to be assessed.)*
Use funds from other sources. *(General Fund dollars currently helping to support Peer Advocacy services.)*

Adoption/Foster Care

Buddy/Companion

(These programs were defunded and service is now provided through Peer Advocates.)

Link to Peer Advocacy, Case Management.
Focus on severity of need.
Populations that are hardest to reach or not getting service.
Training aspects (volunteers).
Specialized volunteer training (e.g., only for emotional support, household activities).
Creativity in implementing volunteer programs.

Day Respite/Childcare

Establish voucher system for childcare to be made available system-wide. *(Not implemented because childcare is available system-wide through in-home childcare and limited on-site childcare.)*
Daycare for moderate dementia. *(Already available through CARE funded program.)*
Home care support for primary caregivers. *(Already available through VH&H contract for Respite Care services.)*

Planning Council Support

Technical support to the Planning Council (see Appendix 3: Glossary of HIV related Service Categories) *(Implemented in Planning Council Support contract.)*
De-fund all IR projects from System-wide development. (REGGIE, ACE, URS). *(Not completely achieved due to Planning Council decision to fund REGGIE.)*
Create and hire Planning Council Staff. *(Achieved)*
Tracking of clients.

Program Support

Create funding "reserve" to address emergent needs on quarterly basis, adjustments to new service structure. *(Achieved through careful monitoring of unexpended funds and reallocation of dollars.)*
Educate programs provider on treatment management issues *(Implemented through HIV Tx Education and Certification program.)*
Training program for case managers *(This has been achieved in past years through training on Case Management standards.)*

Transportation

All transportation related activities from other categories should be funded through this category.
Create a centralized dispatch service for PLHIV's in need of transportation. *(A centralized dispatch service has not been developed due to the absence of funding for such a service. The single provider funded to provide transportation services has a dispatch system in place.)*
Use all CARE-funded vans as part of system-wide transportation system dispatched through centralized service. *(See above)*
Taxi voucher system. *(Taxi vouchers were incorporated into the RFP and awarded along with household and clothing vouchers.)*

Direct Emergency Financial Assistance

Sub-category	Change	Rationale	Severe Need (Priority Population)	Target Services	If more $	Process Used & Implementation Status	Outcome
Provide emergency aid	$100,000	Where system falls down, create a place where PWA's can access	Low income PWA's, PWAs that need assistance Emergency Assistance based on income and disability	Increase to $500,000 with unexpended funds		Award has been increased substantially with HRSA roll-over funds and will be increased further with unexpended dollars.	
Subtotal	$100,000						

Implementation Update in Italics:

Goals and Outcomes:
Recognize emergency needs of PLWHIV that fall through the cracks of the system.
What would funds pay for?
Housing, Food, Transportation?

Linkages to other CARE Programs
Case Management, Housing, Insurance

Current Services
Catholic Charities, Hotel vouchers supplement
AIDS Emergency Fund, one-time short term housing grants
SFAF, Women's Vida Taxi, childcare vouchers
Continuum Case management vouchers for transportation, household utilities, shallow rent.

HIV Health Services Planning Council — Minutes of Meeting, December 21, 1998

DRAFT

I. **Call to order:** 4:30 PM.

II. **Roll Call: [1]**

III. **Review and Approval of Agenda:** Approved.

IV. **Review and Approval of Minutes:** Postponed.

V. **General Announcements:**

- *JB* announced that the phones for the State Office of AIDS will be disconnected for a couple of days starting 11/29/98.
- *TC* introduced Dr. Samuel Kaplan, representative to the Council from the State Office of Medi-Cal.
- *VC* announced that Miriam Farooq is very ill and would be resigning from the Council.
- *NN* distributed, on behalf of *Laura Thomas*, (1) a Health Resources and Services Administration (HRSA) HIV/AIDS Bureau *draft* Housing policy, and a response to it from Mitch Katz, M.D. Dir. of Health, SF. (2) a letter to President Clinton from Mayor Brown asking his support for increased funds to the Ryan White CARE Act and international AIDS programs in FY2000. In addition, he distributed copies of the annual report from the Dept. of Public Health (DPH). He then introduced Dr. Jimmy Loyce, the new Director of the Office of Integrated Care for the DPH.
- *TC* said he had also sent a letter to HRSA regarding their *draft* Housing policy which would be sent to Council members in the next mailing.
- *Michelle Dixon* distributed the announced award from HRSA to the Council's grant application. The San Francisco Eligible Metropolitan Area (EMA) will receive $36,218,513. *VC* asked if additional funds could be targeted to the transgender community. *Michelle* said that she broke funding down by service category and the Council would have to decide if they want to target particular populations. *NN* noted that *Laura Thomas* played a critical role in keeping funding for the local EMA equal to last year's funding.
- *TC* announced that there was $125,000 in unencumbered Title II funds from a Baker Places fund which were shifted to non-ADAP (AIDS Drug Assistance Program) pharmacy costs for Sustiva until it went on the ADAP formulary.
- *Michelle Dixon* said the AIDS Office would submit a proposal for use of unallocated funds for 1999-00 and unexpended funds for 1998-99. *JB* suggested the proposal be sent to the Steering Committee for discussion before bringing it to the full Council.

VI. **Public Comment:**

- *Tony Leone*, speaking as the President of the Derek Silva Tenants Board, has been asked to bring the subject of heat at the facility to the Council's attention again. The heat in the building is shut off at night. The manager of the facility has said heat will be turned on if tenants call and request it. *VC* said that provision of heat is being included in contracts now, and that Derek Silva's contract is up for renewal so the issue should be resolved through the new contract. *Peter Bayou*, acting Program Director of Derek Silva Community, said that he turned the heat on when it was requested and that it would stay on until this cold spell is over. *DJ* suggested that the provider anticipate the needs of residents. *Michelle Dixon* said that a representative of the DPH could monitor the situation.
- *Jim Dilley*, Dir. of the AIDS Health Project, and Dir. of the HIV Mental Health Workgroup, would like to report to the Council in February regarding mental health issues. In addition, he said there was a problem, since the new Request for Proposals (RFP) took effect, with psychiatric coverage in Ward 86 at SF General Hospital. Patients wait up to seven weeks to see providers while eight psychiatric hours a week are designated to be spent at the Tenderloin AIDS Resource Center (TARC) and Glide Memorial Church where, since August, they have seen five clients. He said this is a mismatch of huge proportions.

VII. **Report from Title II Consortium:**

MJW distributed a job description for a Title I Representative to a joint Northern and Southern California HIV planning working group. She recommended a vote at the next Council meeting to elect this representative. The first meeting of the joint group is a three day meeting in April 1999. Council members interested in this position should contact a Council Co-Chair. Nominations and a vote will take place at next month's Council meeting.

VIII. **Mayor's Liaison Report:**

Bill Barnes, AIDS Policy Advisor, announced that the Mayor joined other mayors in sending a letter to HRSA urging them to rethink their *draft* housing policy. The major concerns of the proposed policy are (1) that it requires a doctor's note to get a subsidy; (2) the term "short-term emergency" would lend itself to undue restrictions. He mentioned the letter the Mayor sent to President Clinton regarding increased funding for the Ryan White CARE Act and international AIDS programs in FY2000. He said the Congressional Black Caucus Initiative (CBC) has provided $67,000 in funds to the local EMA and the Mayor hoped the Council would consider a use that would benefit Marin City and East Palo Alto. He said Carol Migden has legislation pending to

assist people of color with AIDS care services. The Mayor's Office is supporting Assemblywoman Migden's HIV Reporting Bill to improve data collection while protecting confidentiality. He distributed a memo regarding the AIDS Summit Implementation that included six recommendations: Two recommendations concerned housing; two dealt with workplace entry and re-entry; one recommendation was concerned with testing, surveillance and reporting; the last recommendation assists HIV positive inmates continue to receive primary care and prevention service. These recommendations will be discussed at the next Steering Committee meeting. He said his office is moving to City Hall in January and they are looking for space large enough to accommodate the Council. He announced that Bill Borden has joined the staff of the AIDS Policy Advisor.

IX. **Committee Reports:**

A. Evaluation and Implementation Committee - *Diane Jones*

1. AIDS Office Draft of '99-00 Implementation Plan
   Michelle Dixon said the plan was derived from the Council's proposed strategy for '99-00. The Council needs to review the document and determine if the AIDS Office correctly interpreted the Council's intent. The document notes where information is needed from the Needs Assessment which means the completion of this project is linked to the Needs Assessment. This document will be narrowed to include only the projects that can be achieved in FY 1999-00.
   Discussion: *LO* asked by what date people need to respond. *Michelle* said people could respond through January. DJ advised Council members to contact *FC* or *AR*, the Co-Chairs of the Evaluation & Implementation Committee, with their questions or recommendations before the next meeting of that Committee. *SS* asked if the document prioritized the level of importance of policy issues. *Michelle* said the document did not. She said, in January, there will be a document that should help prioritize the issues. *DJ* said that the Needs Assessment and the Grantee Assessment would provide important data for evaluation. The Council is looking for leadership direction concerning evaluation. They are discussing this issue with the Dept. of Public Health and the Mayor's Office.
2. Needs Assessment
   A supplemental mailing regarding the Needs Assessment will be sent to Council members. A Needs Assessment Task Force has been formed.
3. Evaluation of '98-99 Implementation
   An Update on Implementation of '98 Proposed Priorities & Allocations was included in the last Council mailing. There continue to be three main categories of services that are of concern in the area of implementation. They are: Latino/a case management services, Youth services, and African American services. These issues will be discussed at the next Evaluation & Implementation Committee meeting. The focus of that meeting will be the *draft* Implementation Plan 1999-2000: Multi-Year. The HIV Service Contractor's Association surveyed their contractors about Implementation. The results will be included in the supplemental mailing.

The next Evaluation & Implementation Committee meeting is Monday, January 4, 1999, 25 Van Ness, Training Room A, from 5:00 to 7:00 PM.
The next Needs Assessment Task Force meeting is Monday, January 4, 1999, 25 Van Ness, Training Room A, from 4:00 to 5:00 PM.

B. Membership Committee - *Loras Ojeda*
LO distributed the report of the last Membership Committee meeting. (1) The Co-Chairs are drafting a response letter to the Mayor regarding the number of applications per Council seat available, and asking the Mayor's Office to participate in recruitment efforts. (2) An attendance review for July to September 1998 will be prepared by the Co-Chairs and recommendations will be made to the Council in January. The Co-Chairs request that attendance be included in written committee reports. (3) A membership application form has been sent to Samuel Kaplan. He has been approved in advance of receipt of his application. *DJ* said an application form will be sent in the next mailing and encouraged Council members to recruit new members.

C. PWA Caucus - Bylaws Revision (VOTE)
The Bylaws revision vote was postponed until the January meeting.

1. PWA Caucus Report - *Tony Leone*
   TL reported that the Caucus needs to elect new Co-Chairs and asked for volunteers. The nomination will take place at the next PWA Caucus meeting, Wednesday, January 6, 1999, 25 Van Ness, Suite 330-B, from 5:00 to 7:00 PM. Currently the Caucus is working on the Evaluation form for the HIV Consumer Rights Advocacy project. They are working to get HIV positive people to serve on review panels and monitor site visits through the AIDS Office.
2. Women's Forum - *Lisa O'Connor*
   LO'C distributed minutes and reported on the Women's Forum held December 3, 1998. Fifteen people attended. The lack of housing was a major issue, but integrated models seem to be helpful. More mental health services in shelters were requested. Medication information is overwhelming to some women with HIV. *SS* asked how information from these forums gets to the providers. *LO'C* said the PWA Caucus would try to incorporate it into prioritization. *TL* said the forums are being held earlier this year so that

the data from those meetings can be included in prioritization. *DJ* said that the Needs Assessment has provider focus groups so the Council will get comments from the providers as well.

3. African American Forum - *Siddiq Jihad & Stephan Oxendine*
   SJ reported that 35 people attended the African American Forum, 30% of them living with AIDS. *SO* said he was concerned that there was a basic lack of knowledge about services and HIV/AIDS in general. He thinks the African American community in San Francisco is not any better informed than in other parts of the country. He said there's a need for basic information about existing HIV services. *SJ* said some African American women spoke about services: discovering their HIV status in hospital emergency rooms; case managers who do not communicate in human terms; the overlap of services that keeps people from getting a needed service at times. He suggested more forums throughout the year. There will be a written report on the African American Forum sent to Council members in the next mailing. There was discussion about trying to provide scheduled dates for the forums earlier.
4. HIV Consumer Rights Advocate Report - *Toni Young*
   Toni distributed a monthly report and a sample of artwork to be used for outdoor and Muni advertising. The ads should be in place by the second week of January. She has had three clients referred to her by the AIDS Legal Referral Panel.

D. Steering Committee - *Diane Jones*
DJ reported that the final job description for the Council's Staff Coordinator will be sent out in the supplemental mailing. She asked Council members to distribute the job description to people who might be candidates for Council staff. She said the Grantee Assessment Task Force had their first meeting this month. The next meeting will be Monday, January 11, 1999, at 25 Van Ness, 5th floor Conference Room, 4:00 to 5:00 PM. She reported that a meeting with *Bill Barnes* to discuss unresolved issues between the Council and the Mayor's Office has been set for Tuesday, January 5, 1999. The time is yet to be determined. A recognition event for former Council members on behalf of the Mayor's Office, the DPH, and the Council is being discussed. She said she discussed alternatives for representation from the San Francisco Health Commission with Leann Monfredini. She reminded Council members that, starting this month, there will be only one council meeting per month and that they are now required to attend one committee meeting each month. *MJW* noted that the bylaws need to reflect this change.

X. **New Business:**

. **Adjournment:** 6:30 PM

The Council meets on the fourth Monday of each month, at the time and place noted above. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For HIV-Positive members requesting excused absences due to illness, contact Tom Calvanese at 621-7712. *Minutes of meetings are tentative until formally approved by the Council.*

12/21/98 HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-]: **Y**=Yes; **N**=No; **B**=Abstain

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	A											
Marianna Balquiedra	A											
Dorothy Bartolomucci	A											
Donald C. Bliss	P											
Chris Boehm	A											
Jeff Byers	P											
Virginia Cafaro	A											
Tom Calvanese	P											
Bart Casimir	P											
Veronika Cauley	P											
Julie A. Charubusapayon	P											
Fernando Chavez	A											
John Conley	A											
Mark Dunlop	A											
Mariam Farooq	E											
Gene Gowdey	A											
Siddiq Jihad	P											
Darrell C. Joe	A											
Diane Jones	P											
Tony Leone	P											
Allen Meyer	A											
Leann Monfredini	A											
Norm Nickens	P											
Lisa O'Connor	P											
Loras Ojeda	P											
Jorge Ortiz	A											
Stephan Oxendine	P											
Alissa Riker	A											
Nilda Rodriguez	P											
Matthew Sharp	A											
Susan Shea	P											
Thomas Sinclair	A											
Brett VanBenschoten	A											
Kelly Wallace	A											
Eric Whitney	P											
Mary Jane Wood	P											

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